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UNIVERSITY OF ALBERTA

The Dance in Caring

Negotiating Nurse-Client Interactions using Politeness as a Communication Strategy

by

Judith Ann Spiers

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Fall, 1994

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Dr. P.A. Field

Dr. J. Dossetor

Date: Aug 11, 1994

DEDICATION

This thesis is dedicated Daniel Scott, whose constant support, patience, and involvement has made this process exciting and satisfying.

ABSTRACT

The purpose of this study was to theoretically develop the concept of *anonymous intimacy*, described by Christensen (1990). A theoretical analysis of the nursing and related disciplines was chosen for the study. Data were collected from the literature on nurse - client interactions, roles, sociological stranger, politeness, caring, coorientation, anonymity, distancing, self disclosure, privacy, intimacy as well as other key areas. The data were subjected to critical analysis and reconceptualization. The concept of *anonymous intimacy* was synthesized into a multidimensional model of four types of nurse -client interaction. They are; Gnostic contact (service-task and role based interaction), Sanctioned privacy (when pathic concerns are addressed but the nurse uses professional nursing resources rather than personal ones to maintain distance), Privileged Intimacy (in which there is connectedness between the essential selves of nurse and client), and Forced Anonymity (in which the nurse and client use politeness to create formality and social distance in order to cope with the embarrassment caused by having a friendship-based prior relationship that is incongruent with the current situation). The main themes underlying the model are politeness, and privacy of person through role guided interaction. The model does not support Christensen's (1990) assertion that *anonymous intimacy* refers to a contextual determinant effecting nurse-client encounters. The type of relationship described by Christensen is re-conceptualized as Sanctioned Privacy, and is a particular style of interaction. It is recommended that the next stage of development is validation in nursing practice.

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I. INTRODUCTION

Many approaches to describing the relationships that nurses have with clients are determined by particular incidents in nursing interactions. The way a nurse expresses sympathy, concern or disinterest, respect or contempt for another person is derived from observations about touch, personal manner, and body language. Interviews with nurses and clients increases understanding of the subjective perceptions about what is happening in the interaction. This information helps identify how nurses establish, maintain, and express caring, through which nursing services are offered. Working from this framework, researchers can then address the variables inhibiting or facilitating effective nursing relationships. In this macro perspective however, the reality that nursing contacts with clients may be extremely brief, often based on a nursing or instrumental activity are observed. In acute care services, nurses may have contact with people they have very little knowledge about, bar the health history. The brief interaction may appear to be task based and superficial (May, 1990).

Nevertheless, even in these brief episodes, nurses have a unique ability to make contact in some personal and caring fashion with the client. It is true, though, that there are times that clients seem reluctant to become actively involved, appearing reserved and quiet, non communicative, and even fearful or embarrassed about what is happening. Other clients seem to be able to connect very quickly to any nurse, and are open and frank with their problems or concerns. There are times also that a nurse simply does not have the internal resources to become immersed in an intense situation. Yet, that nurse may still appear to be solicitous and attentive to the client. Other times the nurse may appear to be just indifferent. The question arises, is an interaction that is characterized by apparently indifference on the part of the nurse necessarily a negative behavior, if it matches with a clients desire to avoid personal involvement or communication that might reveal his/her shame and embarrassment about a sensitive area? How can a nurse best show care and concern to someone she/he has never met before, and may not meet again - and be perceived as sincere? How can dozens of routine encounters with a client - a few seconds, a smile, a simple query, touch, or activity - be ultimately and accumulatively perceived as caring nursing actions? Is nursing most effective even if a client seems not to differentiate between nurses, appealing to nursing rather than the individuals who are nurses?

These were some of the question raised in relation to a concept called *anonymous intimacy*, identified by Christensen (1990), who observed a tendency for nursing clients to identify with nursing rather than nurses, which resulted in the ability to generate immediate intimacy with clients. This thesis is the continuation of the development of that concept,

ending in a theoretical model of some of the possible ways that nursing care can be offered and received while simultaneously protecting or sharing the private self through ritualistic conversation based on various forms of politeness.

Purpose of the study

The purpose in this study was to develop a beginning model and propositional statements about the nature of the concept of *anonymous intimacy*. This was done through a theoretical analysis of the nursing and related literature; in which the existing literature directly and indirectly related to the topic of *anonymous intimacy* was searched, analyzed, and re-conceptualized. The findings from this study may be used to assist nurses to understand how the social sanctions of nursing facilitates the offering and receiving of nursing care.

Research Question

The central question guiding this study was: "*What is the concept of anonymous intimacy*?". Related sub questions which guided the literature search and the analysis are as follows:

1. What are the most applicable definitions of anonymity and intimacy, and what are the ways in which these two are paradoxically linked?
2. What are the boundaries of the concept?
3. What are the characteristics of *anonymous intimacy?*
4. In what circumstances is it likely to occur? Does *anonymous intimacy* refer to the characteristics of a particular part of the process of being nursed or offering nursing, or is it a fundamental feature of all nursing patterns?
5. Does the concept vary? Under what circumstances? Is *anonymous intimacy* related to a specific time and place in nursing relationships?
6. What is the function or purpose of *anonymous intimacy*?
7. What are the related concepts that contribute to it's definition?
8. Does the concept of *anonymous intimacy* contribute to understanding some of the gaps between the theoretical literature and actual nursing practice as reported in verbal or published forms?

This thesis is presented as a journey of development; explanation of the original concept; a more general discussion of the possibilities and problems in defining the characteristics, attributes and boundaries of *anonymous intimacy* as a singular concept; to the final current stage, a theoretical model of some forms of nurse-client interactions. The method of knowledge development and concept synthesis has been through a theoretical analysis of the nursing and associated disciplines' literature (Appendix A).

II. THE CONCEPTUAL CONTEXT

The Nursing Partnership

The concept of *anonymous intimacy* was developed by Christensen (1990), a New Zealand nurse, during her grounded theory research into the nature of the collaboration involved in the giving and receiving of nursing care in acute medical and surgical care. The result was a theoretical framework that conceptualized the client's experience as a complex social process of a passage through a health related event involving hospitalization. The *Nursing Partnership*, or the process through which nursing care is given and received, was characterized as a temporal process of interconnected roles and activities that focused on the nursing client's immediate and potential situation. Within this process there is a patterned interaction or *mutual work* between nurse and client that focuses both partners attention on the clients passage. The client's work is grounded in, and motivated by the need to survive the ordeal, whereas the work of the nurse is guided by the nature of nursing and the individual's ability to select the best nursing strategies to assist the client. Each partner has different expertise which results from their experience and knowledge. This difference may mean that there is lack of balance in the relationship which is reflected in the different language used to describe each pattern of work. The client's work focuses on self and thus the personal aspects of the passage, whilst the nurses work has an altruistic focus on the client's immediate circumstances.

The behaviors of nurse and client are directed by the social expectations of nursing and being a nursing client, as well as the respective expertise and knowledge that nurses and clients have about the health related event. The personal experience of the nursing partnership, which is broadly similar for all people, is greatly influenced by the specific reality of the situation as it is experienced, as well as the larger environmental features that determine how nursing services are offered within the hospital. The physical, financial, technological, social, cultural, and philosophical facets of this environment influence the organization of nursing, which in turn influences the shape of each partnership. In addition to this, the social ratification of nursing as a valued service means that patients have an understanding of nursing, which is reflected by the expectations they have of being nursed (Christensen, 1990).

Christensen (1990) identified three specific contextual determinants within the nursing context that consistently affected the nursing relationship. These determinants are paradoxes that help reflect the specific reality of each nursing situation. The first is *Episodic Continuity*, which describes the paradox in which nursing exists as a series of short intermittent encounters between nurse and client, but the cumulative effects of these

episodes, as well as the knowledge that nurses are continually available, means that these encounters are integrated by both nurses and client into a mutual perception of continuous experience associated with "being nursed"(p.32, 168). Thus, although objectively the reality of interactions is that it is episodic in nature, the subjective perception is a shared feeling of continuity. The concept of *Mutual Benevolence* describes the reciprocal goodwill between the nursing partners that helps sustain the nursing relationship.

Anonymous Intimacy refers to the nature of the relationship between the nurse and patient in which:

> Nursing is characterized by a degree of sanctioned closeness despite the fact that patients are usually nursed by a constantly changing group of nurses, and nurses are faced with an ever changing group of patients as passages are completed and new ones commence (Christensen 1990, p. 45).

Even when clients are confronted by a series of nurses, who are strangers, clients are willing to reveal much of themselves as they receive a variety of intimate services which nursing has the social sanction to provide.

Anonymous intimacy is characterized by the inability of nursing clients to distinguish between nurses, or the ability to correctly name individual nurses. The impersonal forms of "nurse", "the nurse", "she", or even "they," as well as reference to distinguishing features such as uniform color, hair color, or nationality were more common than use of personal names (p.176). Similarly, although nurses were able to recall patients by their names by the end of a duty, the majority of patient's names, or other personalizing details were not retained in the nurse's memory after that particular patient was discharged, and others were admitted.

This mutual anonymity was attributed by Christensen (1990) to the fact that nursing is organized as a 24 hour service which means that both groups are constantly changing. There was little opportunity for individual nurses or clients to form close or ongoing relationships. Christensen concluded that the lack of individualization resulted from the fact that "the patients were identifying with nursing and nurses rather than individual nurses" (p. 176). The following quote illustrates this:

> I couldn't tell you their names...they were all very good...No I couldn't say any special ones at all. They were all exactly the same to me. (Christensen, 1990, p.177).

Despite this apparent lack of individualization of nurses by clients, the nature of the brief contact within each nursing encounter is immediately intimate for the client, in that privacy is surrendered as client's exposed themselves to the ministrations of strangers for physical needs, as well as emotional or psychological concerns. Christensen (1990) regarded this

intimacy as possible because these activities are considered to be within the socially sanctioned domain of nursing practice. She did note, however, that permission for intimate contact was subject to revision as patients continually scrutinized the work of the nurse, and thus the personal aspects of the passage, whilst the nurses work has an altruistic focus on the client's immediate circumstance.

Theoretical analysis and critique

It is difficult to extract a single concept from a theoretical framework for analysis because this removes it from the context in which it was developed. *Anonymous intimacy* is only one of the factors determining the nature of the process and experience of nursing as described by Christensen (1990). It is not clear whether the phenomenon of *anonymous intimacy* would exists as described in other nursing contexts, and other conceptualizations of nursing, or whether it is a concept of use only if nursing is regarded in this manner. To understand how the characteristics of *anonymous intimacy* may be profitably examined, it is important to identify the assumptions and themes in Christensen's (1990) work as a whole. If these are recognized, then understanding can begin within the same conceptual paradigm.

It is evident from both the conceptualization and research method used, that Christensen's work is based on the notion of process (passage) in which the experienced reality is constantly negotiated over time and experience. This negotiation is directed by predetermined role expectations and behaviors (work) adopted by both nurse and client. Each partner is continually involved in maintaining a balance between assuming and playing the expected role of "nurse" or "client", and the disclosure of the individual and private self. The goal of this balance is to negotiate and meet client needs. Self disclosure is greatest on the part of the client, but the nurse must also decide which nursing strategies would be best. Some of these strategies involve revealing the self.

Anonymous intimacy is about the possible and actual intimacy or negotiated boundaries of privacy, that occur between two strangers who have entered a contract for a particular service. The transaction may be brief, however there are rules that are not made explicit, but are nonetheless understood and upheld. The outcome of the transaction is the client's nursing care outcome. For a positive outcome to occur, there must be a degree of sharing, of mutual effort and cooperation. There must be accepted roles to facilitate the client to move boundaries around the self, so that the nurse is able to access private spheres of the client's life to offer nursing assistance. The client's sense of integrity or "face" must be maintained, which gives rise to forms of non-verbal communications and shared

understandings. In the initial stages of interaction, the persons themselves are not as important as the roles and functions that they assume.

The description of *anonymous intimacy* by Christensen (1990) is recognized almost immediately by nurses. However, the level of clarification and precision of terms is ambiguous at best, and largely undefined at worst. Intimacy is described as "sanctioned closeness" without determining whether this closeness is in fact intimacy, bilaterally perceived and accepted; or whether it is in fact, a specific form of privacy. The idea of a relationship between the client and nursing, rather than a particular nurse is also problematic in that this type of relationship is not reflected in the rest of the theoretical framework. The *Nursing Partnership* tends to describe the overall features and possibilities in the client's experience and process through hospital, whereas *anonymous intimacy* is specific to individual interactions. How these two approaches are reconciled is not specified.

Related to this is the ambiguity of the notion of anonymity and stranger. Christensen (1990) identifies the importance of the contact between "people who are essentially strangers..." (p.170), yet the relevant aspect of strangerness, other than the inability to refer to others by personal name is not identified. The role of client and nurse is not strange, even if an individual had not assumed a client role before. Knowledge and experience gained from other social relationships, as well as the media, means that to most people, being or meeting a nurse or client is not a completely unknown situation. This may mean that the interaction is taking place on two levels of simultaneous anonymity of individuality, and congruence and familiarity of roles. This seems to be implied in Christensen's (1990) work, but is then contradicted by the notion of immediate sanctioned intimacy, which, drawing on the rest of Christensen's (1990) model, is highly dependent on the nurse's individual skills and approach, or his/her personality. Thus the term "anonymity" is ill defined, especially in terms of the congruence between one of the assumptions of the model of the primacy of role behaviors, expectations and work, and the essential and private "self".

Furthermore, the idea of a paradox as the basis of the concept is not developed. The opposing/contradictory behaviors of the informants in the study are described by Christensen (1990), but the manner in which informants integrated anonymity and intimacy is not determined beyond the point of identifying nursing as a socially sanctioned service. This is a key issue, central to providing an explanation as to whether this phenomenon is apparent in certain situations such as first encounters, very brief and superficial interactions, or occurring only within a setting (such as a hospital) in which there is a

constant turnover of the nurse and client group. If the key point is, in fact, the turn over of the nurse client groups, then there is an implicit assumption that for some reason clients tend to choose not to expend effort in recognizing the personal identity of the nurse's caring for them. This has some important implications, especially in a culture that holds recognition of individuality important. The implications for ideals such as Primary Nursing, therapeutic relationships that depend on the ability to connect with another on a personal human level are also obvious. Christensen's (1990) explanation of this paradoxical concept, however, contains no connotation of negative or poor quality nursing care or service (although interestingly, this was something that she observed a great deal, but chose not to incorporate into the model), so it would seem as though *anonymous intimacy* needs to be defined as something "that is". In other words, it is a natural feature of the nursing, or hospital environment, something that does not necessarily obstruct or facilitate the offering or receiving of nursing care. It is something so common that unless specifically pointed out, it is not a conscious feature of social interaction.

There are some related concepts, such as self-disclosure and trust that would seem to be important to explaining *anonymous intimacy* that are not discussed by Christensen (1990). These concepts may provide the key in explaining how intimacy and anonymity is simultaneously possible in nursing interactions. Does client self disclosure that is forced inhibit intimacy? What happens to the disclosed information that is far beyond the requirements of the situation? Does this mean that the future interactions are intimate rather than anonymous? The concept of "*Mutual beneficence*, or the mutual, reciprocal goodwill", for example, is described as genuine and consistent appreciation of nurses on the part of clients, which could at times inhibit the expression of true personal negative reactions to individual nurses. It also refers to the efforts of nurses to "coordinate their personal and professional perspectives and to avoid expressing negative feelings about their patients" (p.179). Thus the term intimacy is not clearly differentiated as closeness or self disclosure between role functions or some kind of temporary friendship. Similarly, it is unclear whether anonymity refers to the person, the role, or both.

Summary

Clarification of the concept of *anonymous intimacy* rests on determination of the meaning and purpose of intimacy - or privacy - and anonymity, or strangerness, and how the two terms may be reconciled. The social sanction of nursing which includes implicit assumptions and assurances about how clients may expect to be treated in terms of confidentiality of information, of respect for dignity and autonomy, and trust in the

altruistic function of nursing appears to hold the key to the mechanism that allows simultaneous strangerness and intimacy in nursing interactions.

III. A REFLECTIVE DISCOURSE AS CONCEPT CLARIFICATION

The problems with Christensen's (1990) description of *anonymous intimacy* were initially assumed to be based on the ambiguity of the definition of terms within the concept. The researcher's approach was based on the assumption that *anonymous intimacy* was indeed a single paradoxical concept. The next stage of concept clarification was a reflective discourse in which various approaches to determining the underlying assumptions, approaches, and definitions were considered. At this stage, the researcher assumed that, if the assumptions inherent in the concept, which were drawn from the model of the *Nursing Partnership* as a whole, were identified, then the appropriate definitions of terms would be made clearer. Thus the researcher attempted to investigate the premises of role theory and symbolic interactionism to determine the context within which the rest of the terms could be viewed. The conclusions drawn from this discourse, however, indicated that concept clarification was becoming even more difficult as aspects and attributes of many approaches to intimacy, privacy, and anonymity were applicable. Specific aspects were useful although the researcher concluded that these characteristics could not be used without distorting the original meanings to an unacceptable extent. This conclusion, later to be proved largely unfounded, was directed by the researcher's continuing mystification as to how intimacy and anonymity were reconciled. The researcher's attempts in this stage of concept clarification resembled trying to define the two extremes of a linear process, as well as finding the point in the middle where the two different poles merged and were transformed into the other.

The context of role guided behavior

The concept of *anonymous intimacy* according to Christensen (1990), is part of the context influencing the nature of nursing encounters. To describe *anonymous intimacy*, it is necessary to identify the context upon which it is assumed nursing interaction is based. The context concerns the assumptions about social intercourse, the place of roles in directing or guiding behavior, and the importance of roles in personal identity in the social world.

A macro perspective may be gained by considering how assumptions about social life and interaction may be used to guide perceptions of nurse-client interaction. In functionalist role theory, it is asserted that institutions in society arise because they fulfill a particular need for that society, and that roles are a primary mechanism serving essential functional aspects of the social system (Conway, 1988). Within this broadly defined system, symbolic interaction theory may be used to describe individual action. The symbolic interaction approach to roles is to explain how individuals in reciprocal social interaction

actively construct and create their environment through a process of self-reflective interaction. Social action is a purposeful activity between cooperating persons to meet common goals. Role-taking, and associated social acts enable people to mutually adjust their action to the actual situation, as they engage in establishing a shared perspective. Reality and meaning emerge in this process, as do changes in thinking, emotion, and various biological states. Thinking and communication require the use of shared symbols or language. Thinking is internal communication which allows a person to identify potential alternative behaviors and to select the best for themselves. Communication refers to the expression and interpretation of these meanings. Social processes are formed as people interact, shape, and adapt to their social environment.

People cooperate in social interaction to achieve a goal or outcome. Cooperation requires reasonable consensus between persons on the nature of the situation. So, as agreement develops about the social context, including the anticipated outcomes, it is possible to coordinate activities to obtain a shared goal (Hardy & Hardy, 1988).

Role guided behavior means that each person knows what to expect from the other, and thus has some indication as to how she/he should behave. This is evident in the phenomenon of *anonymous intimacy*. Immediate access to the client is permitted by the client because nursing is a socially sanctioned service. The roles and activities in nursing are expected and accepted as part of the hospital experience. Clients enter hospital with an idea of what it means to be nursed, according to Christensen (1990). This idea is presumably derived from socially created knowledge about nursing. This social knowledge may be created from stories from others, folklore about nursing and hospitals, as well as the media portrayal of nursing. This type of knowledge, however is very general. Clients must learn to "fit in" to the system, to *learn how to become a patient*, by relinquishing their ordinary social role responsibilities, and by watching and learning the behavior of the people in the new environment (Christensen, 1990).

Cooperation between nurse and client is essential to effective nursing care. The goals of the interaction are the client outcome and the preservation of client's sense of self integrity. Recognition of the respective roles of the nurse and client, provides legitimate permission for the nurse to be allowed into the client's private spheres with a minimum of distress for the client. This is all part of the social sanction of nursing noted by Christensen (1990).

In interactions characterized by very intimate nursing activities, such as catheterisation, shaving, or health teaching in relation to very sensitive areas of lifestyle and habits, behavior guides are drawn from this social knowledge. The dominant meanings and expectations within these types of interactions, may be determined by the nurse's verbal

and non-verbal behavior. For example, a "professional" nursing attitude is one that conveys concern but limited personal interest in the client, a focus on the task at hand, and the sense of looking at certain aspects of the person, but not actually noticing other parts. This reductionistic attitude is not necessarily an indication of a disinterest in the client, or an exclusive focus on the task. It could be a deliberate means of creating a communication that provides the client-recipient with some indication of the expected and appropriate behavior and emotions within the encounter. During a very intimate procedure a sense of "distance" may function as a means to allow the client some sense of privacy, integrity, and dignity. The space created by the distancing attitude may be the result of the nurse's efforts to communicate that the procedure is extraordinarily common, that the nurse has performed it many times, and that it should not be a matter of concern or embarrassment for her/him. In this way, both participants use predetermined roles to cope with a difficult and unusual (for the client) situation. The apparent reductionistic nursing approach may be a subtle form of acknowledging the holistic needs of the client. In the same way, if the client's goals of coping include the paramount need to fit into and understand the strange hospital environment, the client may not perceive that recalling the specific identity of the nurse is necessary. Clients may recognize and rely on the role of nursing, appreciating nurses' individual differences and abilities only as time progresses and they become more comfortable in, and familiar with the hospital environment. The symbolic interactionist perspective can be used to determine how nurses and clients appear to utilize generally understood role behaviors and yet engage in individualized and personal nursing encounters. This perspective contains a dual assumption that there is a foundation of common experience and perception of reality and socially normative patterns of behavior, within which individual constructions of meanings in reality are uniquely negotiated and created through interactions with others and the environment.

Self Presentation

In the symbolic interaction perspective, the concept of self, or one's image of who one is, and how others relate to one, is the basis of understanding and explaining human behavior (Pierce, Meloff & Harrell, 1992). There is an object aspect of the self which consists of all the roles that people have in their daily lives - such as student, mother, or nurse. These roles are objective and easily understood by others (we understood what is meant by someone saying that they are a bank teller or a parent. They are socially constructed roles). The subjective aspect of the self is the *self-concept*. This is all the evaluative feelings that are internalized from interactions with others as we play our roles. The nature of the self-concept will determine how one will behave in various social

situations (Pierce, Meloff & Harrell, 1992). The self-concept is continually being developed. As we are social beings, we respond to the reactions of others to our behavior, and modify our behavior in order to evoke a positive rather than a negative response. So, we internalize our perceptions of others' responses (which may or may not actually reflect the other's perceptions). Thus, people continuously interpret and make meaning out of their own and other's experience (Porter, 1988).

Symbolic interactionists assert that individuals improvise a performance based on immediate cues, and the role that she/he infers to the other as a continuing and evolving process of interaction. This could contribute to understanding why nursing clients tend to have a similar interpretation of nurses' behavior in sensitive situations that leads them to choose not to invest energy in recalling the specific personal identities of the nurses involved in their care. A nursing attitude which is designed to communicate a concern for a client's sense of dignity and privacy through an apparent indication of disinterest, may be commonly interpreted as a signal that whilst the present episode is special, the sum of a relationship with a particular nurse is not as important as the entirety of the sense of being nursed. Thus, the emphasis is on the wholeness of the process of being nursed, rather than the actual actors (nurses) contributing to the process.

However, how meanings are created and communicated in these nursing encounters remains rather unclear. The asymmetry of power and authority that exists in nursing relationships derived, as Christensen (1990) observed, from the nurse and client's different sources of knowledge and wisdom, would have a powerful influence on whose meanings dominate. Perhaps in the client's perspective, the situation is directed and defined by the dominant actor, the nurse. The nurse assumes that, because the environment is his or her familiar working environment, clients are also able to interpret and understand the nurse's "common symbols" inherent to the situation and that are not necessarily a means of controlling interaction. The result is that not only can nurses fail to appreciate the uniqueness of a particular encounter for the client, but neutral symbols of communication (assumed by the nurse) are perceived by the client to be positive and negative sanctions for behavior. For example, it is not uncommon for a delay of up to 20 minutes for a nurse to return to a client to address a specific request (narcotic pain relief, for instance). Nurses know the work involved in preparing to administer narcotics, that it can take time to find another nurse to co - sign for the drug, and to find the narcotic cupboard keys. This injection may only be one of many that the nurse will administer throughout the day. The nurse's attitude may be brisk and business-like. The need to explain the delay may not cross the nurse's mind because the delay is expected as a normal part of the procedure.

However, often clients do not know these realities, and time drags on without any apparent reason. It does not take long for clients to realize that nurse response time is often delayed, but in this first period of the client's experience, this delay and then apparent indifference could be understood as a negative reaction to some aspect of the client's behavior. The nurse is assuming that the nature of the reality of the environment is understood. The nurse is able to comprehend the larger context, whereas the client is centered only on his/her personal situation.

Another example of the mystery surrounding nursing routines and behaviors is the way in which nurses appear and disappear seemingly at random. As a nurse, my actions and movements around my clients and around the unit are reasonable and explainable. I allocate time to clients on the basis of care needs. I have general work responsibilities within the unit, and I also plan work around my scheduled rest breaks. I may have a caseload of four to seven clients, as well as attending to visitors, other health professionals, and administrative duties. This complex manner of planning my day will not be obvious in detail to a client, who may be confined to bed or room and thus is able to only witness my presence within his/her sphere. The client will, of course, recognize that I have other clients. However, when people are in a crisis situation and feel vulnerable, then concern centers on the self. All events need to be interpreted in terms of relevance and implications for one's self. Therefore, a nurse appearing once an hour or half hour for only several moments at a time, and obviously intent on accomplishing some obscure task not fully communicated to the client (such as "just need to take your obs.") is likely to be overwhelmingly confusing. Attempting to feel accepted as a competent actor who is in control in the environment, may lead clients to try any strategy to make sense of these interactions. Nursing clients could decide that there is little point in differentiating between individual nurses because all nurses' purposes, actions, and responses seem to be the same. It is only over time, as clients become accustomed to the environment, and are able to make sense of the structure and routine of the place, that attention can be focused on actual personalities. In this process, there is gradually less blind faith placed on the wholeness of nursing and nurses, and more emphasis on the capabilities, competencies, and personality attributes of individual nurses. Christensen's (1990) study indicates that clients' initial openness to all nurses can alter over time. She is not more specific than this, except to say that it was obvious that the work of the nurse is constantly under scrutiny by the client who, in time, can differentiate between groups of nurses, or characteristics of nurses based on their responses and skills. It remains unclear as to whether intimacy with a

nurse who is distrusted or disliked is permitted after a period of time, or whether that intimacy becomes something that is private, but not at all intimate.

Thus, nursing clients inability to differentiate between nurses may be an indication that what is basic common knowledge and symbols to the nurse, is not understood by the client. Clients' interpretation of behaviors and definitions of the situation is not as clear as nurses assume it should be. One way of rationalizing situations that are not completely understood is to move them further away from the self, and to interpret individual actions as characteristic of the whole ("all the nurses are nice", and "this is their job"). Thus, the anonymity of nurses observed by Christensen (1990) could also be attributable to the distancing coping strategies of nursing clients as they attempt to make sense of the mysterious activities occurring with and around them. If this is so, then over a period of time, as Christensen indirectly infers, clients are able to lessen their dependence on distancing and relying on the role of nursing, and begin to note, and appreciate individual nurse's skills and care.

The context of the hospital

The hospital is no different from any other social institution in that it is a reflection of cultural and social values and beliefs about health and illness, cure and care. Yet the world of the hospital contains the power to control and alter the "self" of the persons within it because it constitutes a sociocultural world within itself. It is a bureaucracy governed by impersonal rules and norms, organized to coordinate and control labor, expertise, responsibilities, rights, and authority through an elaborate structure of status, roles, and offices. The focus of this bureaucracy is the state of the human body, which is persistently under observation and analysis (Fox, 1989).

To organize this unending activity, hospitals develop a unique temporal order. This order is highly structured and regulated around shifts, rotations, and the fixed scheduling of patterns of work or specific regular activities. Fox (1989) notes this tightly scheduled hospital time, which dictates when shifts begin and end, when meals and medications are offered, and when patients' days end, is not necessarily synchronized with any personal or even external watch time. The ceaseless functioning of hospitals round the clock is based on beliefs about the seriousness of matters pertaining to life and illness that mean nursing and medical services are indispensable. The cycle of work is organized so that even though individual nurses and doctors are not accessible at all times, the hospital, as an entity, is continuous in providing coverage and care. Attention is directed to the body (of the person) which is investigated, handled, and assaulted in a manner generally only occurring in the most intimate personal relations and contexts by a collection of persons with expertise in

roles that are organized to guarantee continuous observation. Actions, behaviors, and sentiments by both patients and workers are ordered and regulated. Social interaction depends on the ability of individuals within this context to fulfill their socially defined roles.

The emphasis is not on individual identities, but on the roles and activities centered around the needs of a body. The personhood of that body - the "self" - is decontextualised or removed from control over the activities of the body. The monitoring, treatment, and caring activities control how interpersonal interactions occur. However, this does not mean that within the private self, individual feelings and observations do not evolve. Fox (1989) notes that these subjective attitudes must become mostly covert, invisible, and inaudible to conscious interactions because of the acceptance of public social role demands.

The unique sociotemporal order of the hospital environment is familiar to the workers within it, but it can distort patients' normal referents that help them to organize and interpret events, and thus could conceivably diminish their initial ability to associate activities or events with the person carrying them out. However, when there is a crisis of a nature so serious as to disturb everyone's ability to carry out their "normal" roles within the institution, normal interaction breaks down. The emotional anguish felt by the actors exceeds the capability of the roles to deal with it. Whilst the tragedy of childhood leukemia and death goes beyond the scope of *anonymous intimacy* in general situations, the essence of the idea is still useful in explaining how the environmental context of nursing can contribute to *anonymous intimacy*. It is possible that the asymmetry in nursing interactions is not only based on any perceived power or influence belonging to the nurse, but is attributable, in part, to the fact that clients lose their ability to maintain their client-role integrity. Lack of role conformity on the client's part does not mean that the nurse must also discard the nursing role. Nurses can respond to this personal distress from within the nursing role behavior boundaries.

There are times, when a client is so emotionally, psychologically or spiritually distressed, that immediate contact with a nurse is sought. It may not matter to the client which nurse becomes involved. The ideas expressed in Fox's (1989) work indicate that in this type of situation, the boundaries set by role functions and expectations, are no longer sufficient to control the interaction. The nurse, as an observer of the distress being experienced by the client, is able to carry out his/her role functions in terms of the concern and caring for the client, utilizing the work of nursing, described by Christensen (1990) as including responding, listening, comforting, encouraging, and interpreting the client's needs at that time. The client, however, is no longer able to maintain equanimity (or an

acceptable public face, according to Christensen), and reveals the private self in expressing his/her needs. To a client, it may seem as though the usual boundaries of privacy, already disturbed by the investigations and monitoring that have already occurred, are no longer sustainable in the current situation. The client goes beyond the "patient role" to express his/her personal distress although the nurse's contribution to the interaction, communication, and meaning-making, is still possible because the nurse is behaving within the nursing role boundaries of caring.

The interaction occurs between the private personal aspect of the client, and the nursing role. Therefore, the actual identity of the nurse is still not absolutely necessary. Additionally, socialization into the nursing role enables nurses to maintain these role behaviors or attitudes in a wide variety of distressing situations. Cauce and Srebnik's (1990) discussion of the types and purpose of various types of support system support this view, in that patterns of help giving and help receiving are anchored by the mutual obligations inherent in specific relationships. The health care relationship is a formal type of support system in which health care providers provide support as part of their job, their personal feelings being irrelevant in their response.

It would be erroneous to view *all* nursing interactions as something that occurs as an impersonal role interaction between two actors. The strength of the functionalist tradition is the recognition of external forces that shape beliefs about nursing, the context which shapes how nursing is offered, and the constraints, facilitators and controls that influence interaction and communication. It is not a complete explanation. The means by which this is perceived and negotiated - subtly rather than openly - remains only partially explained through the symbolic interaction perspective. The questions remaining are: are role based expectations sufficiently strong to constrain client behavior in situations in which clients' needs for interaction go beyond normal bounds, and are unwanted? What sanctions are used to modify and direct client expectations of nurses, and client behavior? Does an *anonymous intimacy* type of interaction occur only in hospitals as a feature of this unique environment? Is *anonymous intimacy* relevant only to the initial stages of hospitalization - a result of being unsure of one's self through poor understanding of the environment? Is cooperation with nurses resulting from encouraged conformity actually intimacy as defined by common meaning?

Intimacy and Privacy

The concept of intimacy

Christensen's use of the term intimacy is extremely ambiguous. Although the word "intimacy" is used, Christensen refers to "sanctioned closeness", incorporating the notions

of nurses' warmth and understanding in response to clients' self disclosures (1990, p.182). An analysis of the concept *intimacy* indicates that neither intimacy nor closeness are representative of the description of what occurs in nursing encounters; ideas of reserve, privacy, and self boundaries are more appropriate to describe the sense of invading clients' privacy through activities concerned with personal and intimate areas of body or life.

The common meanings of intimacy refer to the quality of nearness and closeness to, and knowledge of, the essential or fundamental being of a person (Simpson & Weiner, 1989). In social science research, intimacy is a multifaceted concept which makes it difficult to arrive at either conceptual or operational definitions (Waring, 1985). The conceptual definitions of intimacy can be divided into three main approaches; the *individual capacity* for intimacy, the *quality of relatedness* as the nature of relationship, and the notion of intimacy as the nature of *individual interactions* (Weingarten, 1991).

The individual capacity for intimacy

The individual capacity for intimacy is the primary focus of the sparse nursing literature on intimacy. In this approach, the focus is on the ability of individuals to express intimacy through personal disclosure. Intimacy is often regarded as a function of developmental ability, such as Erickson's psycho-social stages. Intimacy is seen as an ability developed as part of the personality which is unconsciously influenced by past experiences (Santrock, 1989). Intimacy, as an individual capacity, is a psychological resource influencing patterns of behavior in particular situations. Much of the research on intimacy in this approach is focused on the intimacy pre-requisites required in adult development, role identity, marriage, and social support (Timmerman, 1991). Intimacy in this definition has as its central concern the individualistic, particular behaviors or capacities of people to reveal their personal selves. However, in the hospital context, the expectations and norms inherent in the nurse-client roles often prevail over one's personal and private desires and norms of privacy and intimacy. The paradox of *anonymous intimacy* is that despite apparent disregard of everyday social norms of personal and bodily self disclosure that is required to effectively and efficiently carry out nursing activities, the client's individual sense of privacy is protected as much as possible. So, discussion of intimacy needs to account for the type of intimacy inherent in the type of relationship rather than individual capacities and desire for intimacy.

The quality of relatedness

The second main approach is to regard intimacy as a quality of a relationship, or *quality of relatedness* (Weingarten, 1991). Intimacy in this regard is a fundamental component of interpersonal relationships (Editorial, Psychological Medicine, 1985). Intimacy is a major

dimension used in describing the quality of marriage, normal family functioning, and marital adjustment (Waring, Patton, Neron, & Linker, 1986); a major facet of mental adjustment (Waring & Reddon, 1983), and social support networks (Duffy, 1989).

The facets of marital intimacy as a quality of relatedness include commitment, affection (expression of emotional closeness), expressiveness (of thoughts), compatibility, sexuality, identity (level of self confidence and self-esteem), conflict resolution, and autonomy (Waring & Reddon, 1983; Waring, Patton, Neron, & Limker, 1986). Intimacy has also been measured and conceptualized in terms of shared activity, reciprocal help, exchanges of confidence, liking, and solidarity (Andersson, 1985). Intimacy is also regarded as a situational phenomenon that fluctuates over time (Weiss, 1983 cited in Andersson, 1985). The inclusion of a physical or sexual dimension to intimacy is controversial and not universal in the literature, apparent primarily in the literature on marital relations, therapy, and family studies. A loss of sexual intimacy, however is one of the main themes negatively affecting marital relations, and which can adversely affect and reflect other facets of the marital relationship (Timmerman, 1991; Russel, 1990; Savinsky, 1992).

Interestingly, much research focuses on the absence of intimacy, as opposed to clarifying what the concept is. The absence of intimacy is a contributing factor to the occurrence of depression, non-psychotic emotional illness, marital dissatisfaction, maladaptive family structures, loneliness, and low self esteem (Chelune, Waring, Vosk, & Sultan, 1984; Andersson, 1985; Editorial, Psychological Medicine, 1985); and the inability to form, or the tendency to fear close relationships and intimacy as a result of combat trauma (Sheehan, 1989).

There is little consensus about the conceptual or operational definition of intimacy as a quality of relatedness. This influences how it may be measured. According to Waring (1985), what is being measured is often unclear; - individual partners' intimacy (the individual capacity) or the intimacy existing between the partners (the quality of the relationship). Timmerman (1991) suggests that conceptually, as a quality of a relationship, intimacy is not a characteristic of an individual, and thus can only be examined through the perceptions of the individuals within the relationship as a quality of that relationship.

There are several problems with approaching intimacy as a quality of relatedness. The first is that intimacy is defined in terms of personal or primary relationships, which does not consider the impact of social roles and transaction within social services. Common conceptual definitions of intimacy in this approach, such as those by Timmerman (1991) and Traynowicz (1986), include the attributes of reciprocity of trust, emotional closeness,

open communication, and sensitivity and acceptance of the other's vulnerability, reciprocal self-disclosure, and mutual exchange. These attributes, Timmerman (1991) argues, mean that therapeutic relationships cannot be described as intimate. This is because the relationship is goal oriented toward the well-being of the client, which does not allow the nurse to be truly free to be his/her personal self, and so must selectively disclose the self based on the benefit that disclosure will have for the client. In other words, the impact of social roles, and the influence of social norms on behaviors and expectations does not permit intimacy based on the idea of being one's true self. Intimacy derived from use of professional persona rather than one's true self is not considered true intimacy.

Christensen's (1990) use of intimacy in *anonymous intimacy* requires that intimacy be regarded in terms of professional relationships. Intimacy is a common feature of most nursing encounters rather than unique or special interactions. In other words, some type of intimacy occurs regardless of the actual individuals involved. Intimacy occurs as the result of the role functions, rather than personal desire. Thus the dimensions of intimacy such as affection, commitment, reciprocity, and trust to describe intimacy in personal relationships are not entirely appropriate.

The second main problem with the use of intimacy as a *quality of relatedness*, is that the total relationship, rather than the sum of individual interactions is regarded as intimate or non-intimate. This implies that single interactional relationships between strangers or acquaintances are falsely regarded as intimate, as having neither a past nor often an anticipated future. The *quality of relatedness* view seems to be flawed in that the global view of the relationship, the focus on the general nature of the relationship which assumes interactions, does not address the importance of individual interactions as the basis for building intimate relationships. Thus, a once-only interaction between nurse and client cannot be considered to be true intimacy. This is reflected in Christensen's (1990) claim that *anonymous intimacy* refers to the fact that client's seem to identify with nursing rather than with individual nurses. The lack of opportunities for closeness preclude the development of a personal friendship, but within a generally non-intimate relationship with an entity known as nursing, intimacy in some form can occur within interactions. The aspect of intimacy as the nature of individual interaction is probably the dimension that can support the paradox of intimate self-disclosure between strangers.

Intimacy as the nature of individual interactions

There are two main approaches in regarding intimacy as the nature of individual interactions. The first is that an intimate interaction occurs when people share or co-create meaning, which, if repeated, results in an experience of intimacy (Weingarten, 1991). This

process of sharing meaning - knowing and being known by another - involves a relational pattern including trust and reciprocity within a temporal context of past, present, and anticipated future. The temporal nature of this definition is problematic in application to *anonymous intimacy* as it is the relationship between client and nursing rather than the nurse that is assumed to have a temporal dimension.

The notion, however, of intimacy as co-creation of meaning within particular interactions is useful. Weingarten's (1991) definition excludes any imposing, providing, rejecting, or misunderstanding of meaning, which can occur in nursing situations within "intimate" interactions. The question then becomes whether co-creation of meaning can be subconscious or occur by inference. In other words, by accepting nursing services, one accepts that some activities occur for a purpose that may or may not be deliberately misconstrued or ignored by the actors in order to preserve a sense of personal integrity. Weingarten (1991) assumes that the creation of meaning is indicated not by what people talk about or reveal but whether each person *feels included* in the creation of meaning. This is problematic as it is possible that one can feel included in meaning-making yet be misunderstood. It is dubious whether the definition of intimacy as meaning-making is appropriate to situations in which the client is unconscious, or in which the client is the subject of communication, but who is ignored. Some of the behaviors characterizing *anonymous intimacy*, such as blurring of nurses' identities, inability to recognize names, and the assumption of "professional" attitudes, may be the result of subconscious or social constructions of meaning which act as precursors to intimacy within particular encounters. However, taken in the pure theoretical form, the rules and learned or expected behaviors surrounding nursing interaction precludes the possibility of intimacy as meaning-making. Theoretically, the idea of ritualized forms of interaction and communication as a precursor, a process, and an outcome of mutual meaning-making is useful, but probably not a conscious action in nursing reality. It is uncertain whether intimacy as meaning-making - as consensual agreement on the unique experience of the interaction - or some modified form of mutuality and coordination of action, could be used to represent the meaning and intimacy that is created and experienced in nursing interactions.

In the second interactional approach intimacy evolves in stages as a consequence of unique conditions of joined and intimate behavior. In this way intimacy can occur within a single encounter, social action, or relationship. Interactional intimacy is brief interaction without a temporal dimension and within which there is insufficient time to disclose the core self. The key is that the actors indicate a willingness to be available as self beyond that called for by the context (Traynowicz, 1986). In other words, a single interaction can be

based on a need mutually recognized by two people involved in particular role behaviors. The necessary conditions are perception of and interest in the other as total human beings, either as subject or as object. In this way, the goal focus of nursing interactions, objectification of tasks or problems, and role playing - nurse and client roles - does not preclude the possibility of intimacy. The ability to manipulate role-person balance and focus on the need of the moment is the critical issue. *Intimate social action* (Traynowicz, 1986), refers to action oriented toward greater familiarity and understanding of the other within a sense of private togetherness and personal responsiveness. This can occur within a brief interaction and is applicable to nursing interactions which occur in response to crisis situations and where the nurse chooses to respond in a more personal manner.

The conclusion at this point is that the concept of intimacy is not well defined either theoretically or through research. There are attributes in many of the approaches that would seem to be appropriate to *anonymous intimacy*. The difficulty seems to lie in the fact that *anonymous intimacy* includes not only the paradox of anonymity and intimacy, but the simultaneous occurrence of intimacy between client and nursing, which may be a quality of a relationship (based on the sanctioned role that nursing has in health care), and the behaviors of intimacy that may occur between individual nurses and clients. The mediating factor appears to be the manipulation of the person-role behaviors which direct self disclosure and involvement and which in turn influence the potential of co-creation, imposition, or misunderstanding of meaning. This complexity and paradox leads to the possibility that the use of the term "intimacy" in Christensen's (1990) concept is a mislabel. It is possible that some notion of privacy, reserve, or control of self boundaries is more appropriate.

Privacy

If intimacy, reaching out of one's self in order to connect with another person, is not entirely appropriate to describe the routine contacts between nurses and their clients, then perhaps the notion of privacy, or manipulating the boundaries that separate "self" from the rest of the world (or at least parts of the self) is more useful. Although the conceptualization of privacy is as broad as that of intimacy, no single conceptualization fits the attributes of *anonymous intimacy*. As with intimacy, privacy may be conceptualized as a state, a feeling, or a process. Privacy can be regarded as belonging to the individual or as a product of the nature of the interaction. It is considered to be an embracing concept consisting of four stages or dimensions; solitude (loneliness), intimacy, anonymity (where behavior is dissociated from the person), and reserve (Westin, 1967, cited in Bersceid, 1977). Privacy is also regarded as an individual capacity, so that in social interaction the ability to conceal

an aspect of his/her person from public view provides a sense of freedom from interference or intrusion (Simpson & Weiner, 1989). Conceptualizing privacy as autonomy in thought or action resulting from control over personal boundaries between the self and others, is a common theme in the literature (Laufer, 1977; Berceid, 1977; Kelman, 1977). The main process through which this occurs is impression management and self presentation (Kelman, 1977). Privacy as a function of personal choice is regarded as problematic by some authors (Kelman, 1977) as control over personal information is often a feature of the social environment and in particular, the attributes of the social role assumed in the interaction rather than personal choice.

In nursing situations loss of personal control is often expected as an integral part of the client's role. It is likely that a process of objectification, or separation of "self" and information or bodily exposure, combined with privacy as impression management, allows interaction to occur whilst permitting the individual to feel autonomous or free within their own private psychological space (Spiers, 1993). This process is indicated in Christensen's (1990) categories of clients' work of *Managing Self* in which clients focus on developing an internal state of composure and serenity, whilst perceiving a need to present an acceptable face to others. *Affiliating With Experts* refers to the work that clients do in acquiescing to the experts responsible for their care whilst protecting autonomy through retention of thought and action. How this is integrated with *anonymous intimacy* is not clear.

Applegate (1992) notes that the nursing research in the area of privacy for nursing clients is concentrated primarily on attaining personal space and territoriality rather than preserving privacy within individual nursing encounters. These concepts of space and territoriality as well as the notion of reserve, psychological non-participation or withdrawal are important related concepts within *anonymous intimacy*. One dimension of intimacy which is integral to the notions of privacy-intimacy regulation is the concept of self disclosure, that is, determining how much information one presents and how it is presented to others.

The self disclosure mechanism

Self-disclosure is commonly defined as the act of truthfully, sincerely, and intentionally revealing personal and ordinarily private information verbally, and less frequently non-verbally (Derlega & Chaikin, 1977; Zerubavel, 1982; Fisher, 1984; Miall, 1989). It is the perceived role relationship between two people that is the main influence on one's willingness to disclose (Balswick & Balkwell, 1977). Boundary regulation or the degree of openness to others while maintaining a balance of need for privacy, is an important aspect

of the ability to create intimacy with another person. One aspect of self disclosure, the depth of intimacy dimension, allows individuals to differentiate between information about the self which is concerned with central issues, or areas of vulnerability, and those which are more distant in nature, and considered to be superficial and distant to the private self and thus non-intimate (Derlega & Chaikin, 1977; Zerubavel, 1982).

Distancing or objectifying an aspect of the self, such as body functions or information about private aspects of one's life, is one way of protecting the private self while allowing the self disclosures necessary to achieve the health care need. Allowing intimacy through self disclosure is a means to a particular end, the health care need. Disclosure of sensitive areas of one's self may be temporarily segmented from the rest of one's sense of self to ensure that possession of that disclosure does not make the client feel over-vulnerable. Derlega & Chailin (1977) suggest that another dimension of self-disclosure, breadth of disclosure, is an important mechanism to control interaction contact. Depth of personal information is replaced with a range of less personal disclosures, which allows the individual to avoid the appearance of aloofness or being non-communicative through superficial information disclosure.

The difficulty with much of this research on self disclosure, as with the research on intimacy, is that it is based on personal relationships rather than professional ones. Thus the influence that cultural, social, or organizational norms have on behavior and expectations is not considered. Health care workers, acting within the sanction provided by a socially defined role often invade patients physical and informational private areas. In nursing research, Applegate (1992) indicated that respect for the norms and expectations regarding privacy and control of interactions, as well as the attitude toward the other in long term nursing care, is variable depending on the antecedent of respect for the individuality of person-hood. She found that the norms related to privacy in long term care facilities may reflect the mores of the providers of care in terms of efficient care, rather than those of the residents. Morse's (1991) study supports the notion of breadth versus depth of self disclosure in that clients control intimacy and privacy by withholding information, concentrating only on the symptoms of the illness and treatment, or by expressing disapproval through avoiding eye contact if they perceived a lack of mutual trust in the relationship. Nurses too controlled clients' disclosure through depersonalizing measures such as adopting an appearance of efficient business, lack of informal social interaction, and the persistent use of formal titles.

Related Concepts

One of the primary goals in the concept clarification of *anonymous intimacy* is to determine the boundaries between intimacy and privacy. Related concepts such as trust, may provide a means to integrate aspects of privacy and intimacy. Christensen (1990) indicated that trust is an aspect of *anonymous intimacy* by referring to nursing as a socially sanctioned, and therefore a trusted and accepted role. Creating intimacy, however, is mediated by clients' trust and confidence in individual nurses' effectiveness.

A trusting relationship, which includes negotiation about confidentiality and boundaries of privacy, is essential to alleviate fear and to facilitate communication (Glaser, 1982). Thorne and Robinson's (1988) study of chronically ill clients' perspective of community health care workers also showed that trust was a recurring theme. Naive trust in health professionals at the beginning of a relationship was quickly destroyed as clients realized that the professional was not concerned with their perspective of their needs. A reconstructed trust could be built over time as the client became familiar with the staff's skills and limitations. This trust, however, is based on a relationship of guarded alliance which relies on the predictable patterns of professional behavior rather than on particular individuals. Time, the development of a sense of personal competence, and knowledge about the health care system were significant factors in the redevelopment of trust. This study is instrumental in illustrating how trust in the entity of nursing, rather than the individuals who are nurses, facilitates intimacy in nursing encounters. Morse (1991) identified the inability to develop trust as a negative influence on nursing relationships. She found that a number of factors affect trust including the violation of confidentiality of information shared between nurses, lack of time, and multiple care-givers. Unlike Christensen (1990), Morse believes that the assumed interchange-ability of caregivers adversely influences effective nursing relationships. The findings of Knight and Field (1981) support the view that trust based on perception of the other as an individual, was fundamental to the ability of nurses to form sound relationships with patients. Lack of time and the freedom to discuss issues with clients were also found to be factors limiting nurses' trust building ability. Lack of trust-based relationships resulted in routine, task oriented nursing. This is contradictory to Christensen's (1990) finding that it is the relationship with the role of nursing rather than individual nurses that is important. Effective nursing encounters can occur because clients, at least initially, are receptive to representatives of nursing rather than the individuals who are nurses.

The issue of balance between nurses' professional and personal approaches is a crucial area in *anonymous intimacy*. This balance is dependent on reciprocal social intimacy, trust,

commitment, and respect for client dignity (Morse, 1991; Knight & Field, 1981; Hunt, 1991; Kitson, 1987; Ramos, 1992). May (1991) found that the balance between neutrality and involvement based on reciprocal social intimacy (finding out about each other as social human beings) was essential to provide a relationship that was both meaningful and individualized. However, the relationship was bound by strong norms of acceptable professional behavior as well as the organizational requirements of the nurse, which were separate from the care of the nursing client. Satisfactory relationships in terms of outcomes were those in which nurses' sensed equilibrium between the professional role and a personalized approach. This balance, nurses reported, allowed the client to have a sense of personal recognition without preventing the efficient organization of work and delivery of care.

Morse (1991) and Thorne and Robinson (1988) found that negotiation of nursing relationships is dependent on the patient's perception of the seriousness of his or her own condition, and feelings of vulnerability and dependency. If the type of care required was technical only, then a brief, nurse oriented, superficial and courteous relationship ensued in which the nurses were invisible and interchangeable with no expectations made of them beyond actual activities accomplished. However, as needs and dependency increased, clients sought a more meaningful and connected relationship. The clients began expecting the nurse to act as advocate/protector and relied on both the nursing role and personal attributes. Applegate (1990) found that technically task oriented and impersonal care and interactions were attributable to the nurse and client's lack of recognition of the other as a unique individual with specific qualities and characteristics. This was regardless of the actual type of care perceived as required by either resident or caregiver.

The effect of the organization of nursing on privacy

The influence of the realities of the organization of nursing and client services, such as the 24 hour nature of nursing, high workloads, increased client acuity, and changing work patterns (such as the admission of clients to pre-admission units, with transfer to inpatient units from the operating theater) on nurse-client interactions are areas that need to be examined for attributes and contexts of *anonymous intimacy*. Christensen (1990) attributed the paradox of *anonymous intimacy* to the scheduling patterns and the constant turnover of both nurse and client groups. This is supported by Francis (1980) and Melia (1982, cited in Kitson, 1987) who indicate that the contractual nature of nursing, and the fact that it is a secondary bond rather than a primary one (as in a family) preclude to a large extent the ability for a nursing relationship to be based on acknowledging the full personal nature of another, or to be lasting, or constantly intimate. Applegate's (1990) study of long term care

residents, however, identified that residents' ability or inability to name or distinguish staff by identifying characteristics is not attributable to staff rotation schedules, but whether or not the resident chose to perceive the caregiver as a unique person, and to have an interest in the caregiver beyond the care giving role. Thus it is the attitude and, to a certain extent, the balance of power that influenced the stranger-ness and intimacy within interactions.

These nursing studies indicate that there is little consensus about the importance of concepts such as respect, privacy, and role behavior/personal response balance in nursing relationships. Although some findings are relevant to the concept of *anonymous intimacy*, a major confounding factor is that all of these studies identify the factors influencing the general approach to nursing relationships. The paradox of *anonymous intimacy* suggests that although the organizational requirements of a nursing unit do not support the establishment of a trustful and connected *interpersonal relationship*, closeness, intimacy, warmth, and caring can occur within interactions, even if the nurse and client do not necessarily perceive the other as an individual, but as a representative of a particular group.

Anonymity

The meaning of anonymity

According to Christensen's (1990) description, anonymity refers to clients' inability to identify nurses by name. She found that it was exceptional for a nurse to be recalled by name, although this did not necessarily mean that the client would not be able to distinguish the nurse from others by sight. Those nurses who were identified consistently by name tended to be those who had a significant distinguishing feature - such as hair color, height, or being a male nurse. Christensen found that quality of performance was not particularly linked with those being named. Instead, clients tended to use impersonal nouns such as "she", "they", and "nurse". Nurses too, displayed some of these tendencies, but generally were able to link the correct name to the correct client by the end of a duty, although personalizing details were quickly lost once the client was discharged. This anonymity was attributed to the brevity of contact and the multiple numbers of nurses in contact with a particular client during that client's hospitalization.

Alternative explanations for this tendency are difficult to consider as it is unknown whether nurses wore name badges, or if formal introductions occurred in each nurse/client relationship or encounter (although generally, standards of nursing practice, hospital security and ordinary courtesy would indicate that this might occur). It is not apparent whether this function is a characteristic of short term hospitalizations, or whether it continues or decreases over time in the client sample used by Christensen. Applegate's (1990) research showed that this type of anonymity was attributable to choice and power

balance and the decision to respect the unique individuality of the other. The more respectful of individuality, the more likely it was that the resident would be able to identify nurses by characteristic, if not by name. Interestingly, in this study, the inability to name nurses was incorrectly attributed by clients to the constant turnover of nurses.

De-individualization and depersonalization

The use of the term "anonymity" is problematic as Christensen's (1990) use of the term does not fit well within any common usage of the word, such as those found in the *Oxford English Dictionary* (Simpson & Weiner, 1989; Spiers, 1993). Alternative concepts such as de-individualization and depersonalization may in fact be more illuminating than the idea of anonymity because the anonymity of nurses does not imply that clients perceive them as without personal identity, but that it is the actions of nursing that are familiar and recognized rather than the actual actors. This perspective is supported by Applegate's (1990) work in which blurring of individual identity in the resident's perception occurred because the resident did not perceive that the caregiver existed beyond the care giving role.

The concept of de-individualization, which refers to the loss of one's sense of identity (Reber, 1985), is generally used to explain the loss of behavioral restraint and high aggression that may accompany anonymity in group or mob situations, when individual separateness is lost and individual choice is submerged in anti-social group action (Smith, Sarason, & Sarason , 1982). However, some studies have pursued this phenomenon within the bounds of normal social roles. Valacich, Denis, & Nunmaker (1992) show that de-individualization as *anonymity of identity* can facilitate or produce more frank , open and critical communication in individuals or groups than from those in which individuals are identified. This loss of perceived individuality in the hospital illness experience may be one factor encouraging intimacy in nursing relationships.

The concept of *depersonalization* may represent this loss more accurately. Depersonalization has a variety of meanings, the dominant one being "the feeling of loss of self or of personal identity, the sense that one is but a number in a computer memory bank or mere cog in a blundering, dehumanized, social machine" (Reber, 1985, p.188). According to Watson (1988), loss of privacy, or anonymity of self to others, results from the depersonalization that occurs with hospitalization, and the intimate procedures and investigations associated with hospitalization. There is an expectation by hospital staff that the patient will share intimate information and expose his or her own body without reserve. Patients become objects of care, or depersonalized and anonymous cases, through nurses' failure to attempt to know the client, including the client's self, life space, and phenomenological view of his/her world. Applegate (1990) indicates too, that

depersonalization is the result of the inability or desire not to regard a person's individuality and uniqueness beyond the care-giver and care-receiver role. Hitchcock and Skodol Wilson (1992) provide an example in which this objectification, or as they term it, invisibility, serves to often protect lesbians who must continually choose whether or not to reveal their lifestyles to health professionals. Deciding not to reveal their sexual orientations protects them from personal rejection, but simultaneously disallows the health professional from knowing them as a whole within the context of their lives. The paradox that exists in Christensen's (1990) conceptualization is that despite this general depersonalization, routine nursing encounters can be highly individualistic, warm, and caring.

Anonymity and Intimacy

The work of Schutz (1971) on the nature of taken-for-granted world of daily life, provides an important insight into integrating anonymity and intimacy. According to Schutz, one expects and perceives a typical world of events and people. Typicality means that one knows few people, but interacts with many who are anonymous. Social interactions are based on typification, or the set of expectations of how the anonymous other will act in typical circumstances. However, when one approaches a new social group, one is a stranger in that old patterns, behaviors, and expectations are no longer appropriate to the new situation. In an attempt to define the new reality, strangers construct a world of pseudo-anonymity, pseudo-intimacy, and pseudo-typicality. This allows interaction through performance and expectation of typical behaviors. In relation to *anonymous intimacy*, clients extrapolate the characteristics of one nurse to represent the total group or assume that one individual is representative of the group rather than part of it *and* also different. There is an oscillation between remoteness and intimacy as clients learn to fit in and identify with the hospital group. However, if this is so, then logically this typification should only occur during the first part, or the first admission to hospital, lasting only until the client gains sufficient experience and does not need to rely on false typifications to interpret the environment. Unfortunately, this speculation has no base in research; it was not determined by Christensen (1990) and was not evident in studies such as that by Applegate (1991).

The sociological and anonymous stranger

Attributes of the concepts of the sociological and anonymous stranger (Shutz, 1971; Cressey, 1983) in social interaction and participation in groups has also been identified as important in establishing characteristics of *anonymous intimacy* (Spiers, 1993). The types of stranger characteristics influence how interaction is initiated and maintained, including the importance of social roles, social status, and contractual relationships. These concepts

are important in identifying the ability of individuals to remain simultaneously near and far from a group, inviting and controlling intimate contact by virtue of the recognition of the role pattern and role status. The role status of a sociological stranger - for example a researcher - in a group can facilitate confessional rapport as long as the stranger conforms to the role patterns assigned by the group to that particular role. There is generally definite segmentation and control of the areas of depth and breadth of self disclosure by members of the group. Also, the stranger has the potential to manipulate his or her relative role/personal person balance to create different contexts of formality and friendliness, which in turn influences the type of information offered by the group. In general,. anonymity, caused by the absence of personal identity, the mutual awareness that the relationship is not based on prior knowledge or assumptions about the other, and no expectations for the future, facilitates intimacy and self disclosure of normally taboo information. Any revelation of personal identity indicates the end of the anonymous role, and often the contact (Shutz, 1971; Cressey, 1983). The anonymous stranger is the relationship of casual acquaintances, who meet anonymously and exchange experiences and sympathy. These are transient relationships, likened by Glazer (1982) to talking to a stranger on a plane, which rely on the invisibility or impersonality of the individuals to facilitate disclosure of often taboo information (Shutz, 1971; Cressey, 1983).

Nursing shares some similarities with the type of sociological stranger contact. It is a formal relationship for a defined purpose and initiated by an introduction of social identity; name, role and status for the nurse, name, health need and often occupational characteristics for the client. Intimacy occurs not so much between the people who are nurse and client, but the accepted patterns of nurse and client roles. These patterns are based on an expectation of confidentiality which facilitates immediate intimacy and disclosure on each contact *no matter* which individual occupies the role of nurse. Over time, as clients become more familiar with the environment, they are able to discriminate, and thus control intimacy based on perceptions of the characteristics of particular nurses. However, intimate contact with nurses, especially in short term hospitalizations may be fostered by the client's knowledge that the nurse may never be seen again. Facilitated by an overall confusing environment, personal identity is repressed, which helps one endure or permit uncomfortable or highly personal disclosures. The reciprocity of disclosures is mediated by the understanding of the purpose of the relationship - disclosures by the nurse are not required, unless the nurse decides that it is necessary. Client disclosures may be supported from two sources - the knowledge that the contact with nurses is transient, and the assumed understanding that much of the content is shared within the nursing group.

This may foster the assumption that all nurses are equally familiar with one, and removing the need to discriminate between actual persons. These characteristics are supported in the work by Morse (1991) on the negotiation of the nature of the nursing relationship.

Other Settings

To date, the work on the conceptual clarification of *anonymous intimacy* has been focused on the concept as it occurs in acute care nursing areas. Consideration needs to be given to the form that *anonymous intimacy* may take in other areas of nursing, which will provide an indication of whether *anonymous intimacy* is in fact a product of an environment dominated by large volumes of client throughput, resulting in the inability for nurses to offer more than brief care, or whether it is part of the general cultural norms governing how nurses and clients perceive and expect care and interaction. Applegate (1990) found that time was not a factor in interactions in the long term care of institutionalized elderly; the determining factor was the attitude of nurse and resident in terms of respect for uniqueness of person-hood. Interestingly, the individual identity in terms of names of nurses was not a major factor in interactions that were respectful of individuality, but were in interactions that were perceived as dehumanized or routine. Field (1987), in contrast, found that part of parents' perception of individualized care consisted of parents knowing the individual identity of their nurses. Hunt (1991), in research on care of the terminally ill and their relatives at home, found that informality and friendliness, through use of first names and not wearing uniforms facilitated interactions, and that professional manners, characterized by detachment, suppression of emotions and repression of individual identity were fostered through uniform wearing and use of formal titles. Ramos (1992) indicates that anonymous interactions occurred independently of the type of nursing area, and were determined by factors including the patient being unconscious, having little time to spend with patients, or when the nurse and patient were strangers. It was further noted that any superficiality of interaction was believed by nurses to be hidden by their acting ability and ability to behave as if the contact was very important.

Other theoretical indications

Christensen (1990) describes her model the "Nursing Partnership" as a theory that focuses on the possible. The theory evolved from analysis of practice, and tends to reflect the excellence found in nursing practice, rather than the harshness and poor performance. As she notes, retaining the ideal/real dichotomy is of little use to those seeking a guiding theoretical framework for nursing practice in an increasingly complex environment.

There are indications in a number of theories or models that *anonymous intimacy* is a fundamental, although controversial feature of nursing. The theories based on the centrality of caring to nursing, refer to nursing as an artistic response with authentic presence. No nursing occurs, even though treatment and tasks are administered, unless there is a specific intent to care (Schoenhofer & Boykin, 1993). Peplau perceives the nurse's role of *stranger* as part of the four phases of the nurse-patient relationship in which interaction is non-personal and where patients are offered the ordinary courtesies that are accorded to a guest being introduced to a new situation. The nurse's interaction in the initial stages of a relationship with a client, unlike the work of the sociological stranger (Shutz, 1971) which is based on assumptions of typicality, includes accepting persons as they are, and relating to the person as an emotionally stable stranger, until there is evidence to change these assumptions (Peplau, 1952, cited in Reed & Johnston, 1983). Orlando states that it is the function of the nurse to help the patient maintain or retain a sense of adequacy or well-being in stressful situations by recognizing the nature of the distress, and identifying the appropriate professional function. This requires that each person relearns the other's individuality and ways of offering and receiving help in each nursing contact encounter. This perspective may be helpful in broadening an understanding of how the paradox of stranger-ness and intimate closeness is resolved. Other theories such as those by Watson (1988), Parse (1981) and Paterson and Zderad (1988) which include aspects of mutuality, unfolding of meaning and inter subjective interaction, perception and creation of realities and meanings, within a constantly changing environment of personnel, roles and functions, may also be important in determining whether *anonymous intimacy* is defined in other ways. Orem (1980) postulates in her model that effective nursing is dependent on an environment of trust in self and role, thus trust exists and is implicit in the roles within the legitimate relationships of nursing. This would support the notion that a relationship can develop between the roles assumed by persons and is not, at least initially, dependent on the personalities involved.

Conclusion

The concept of *anonymous intimacy* refers to the ability of two strangers to enter into intimate moments immediately, without the establishment of a previous relationship. The results of this ability are the ease for the nurse to inquire, identify and meet the client's health care need while maintaining a sense of privacy for the client. The basis of this ability is the trust that nursing clients have in the social sanction given to nursing. One of the consequences of this trust, at least in acute care areas, is that individuals nurses are not perceived as individuals, but as representatives of the group of nursing. This allows clients

to identify and seek assistance from nursing in a hospital environment that may be overwhelming in the initial stages of hospitalization. Disclosing the self by clients may not be an attempt to create intimacy, but permission to enter the inner boundaries of the self. However, it is clear that the environment of hospital and nursing contains norms, forms of communication or understandings that facilitate nurse-client interaction and closeness based on a mutual understanding of client and nursing roles. The mechanism through which understandings of roles and expectations of behavior are negotiated within nursing encounters is not determined. It is proposed that the same or associated mechanism is also responsible for allowing the client to manipulate the boundaries of public and private information about the self, in order to retain as much sense of personal integrity as possible.

Critique of the Present Phase of Concept Clarification

Although many useful ideas about how *anonymous intimacy* could be defined are presented in this chapter, the strategy used is ultimately unlikely to achieve a significant amount in terms of clarifying *anonymous intimacy*. The first reason is because the goal of this work is centered on attempting to define something that has not been understood or described, and the second reason, related to this, is the researcher's determination to find single definitions for the two poles of intimacy and anonymity. The discussion contains numerous indications that a variety of feelings, states, interactions, ways of being and communicating are involved in *anonymous intimacy*. Attempting to reduce this complexity by overlooking the interrelations between the variations on intimacy, privacy and anonymity in favor of a single process has resulted in confusion and ambiguity.

The determination to discover one particular definition of intimacy, such as intimacy as privacy, or some variation of privacy that is congruent with the definition of anonymity is been a major problem. The researcher's assumption appears to be that if those two concepts on the continuum of intimacy and anonymity were defined, then that would elucidate the mechanism integrating the two. Unfortunately, it is difficult to define something that is well known, and trying to define something that is only vaguely understood simply results in unproductive and often contradictory speculation. Many ideas are regarded as attractive, but then discarded when they are unable to meet all demands or applications of the concept. Finding an integrating mechanism at this level then becomes premature. The concepts of sociological and anonymous stranger are of value, in comparing how the relationship may be similar in terms of transient nature and influence of limited knowledge but set expectations of the other, but even this fails to explain how this influences guarding or manipulation of personal boundaries.

When the actual act of guarding self is recalled as critical to *anonymous intimacy*, the relevance of "strangerness" becomes even more vague. The sociological stranger's ability to elicit information is based on formality and confidentiality of anonymity in terms of the future uses of the information by the researcher. The anonymous stranger relationship relies on the presentation of the private self rather than public or social roles. Control over self disclosure is lessened because of the security contained in the knowledge of anonymity, and lack of anticipated future contact. Neither of these two situations are fully congruent with most nursing relationships. Information certainly should be confidential, but within the group of nurses and other health professionals it is specifically linked to the client's willingness to disclose information beyond the requirements of the situation. Client self disclosures, although sometimes willingly uncontrolled, are more likely to be carefully

directed, depending on the client's particular need. Thus, discussion about how these types of stranger-relationships might be the key to understanding nursing relationships is of very limited use.

Although not specifically speaking to nursing relationships, Van den Berg (1966) makes a pertinent observation that in contact between a doctor and patient, when the doctor is with the patient, he/she is *not* a stranger to the patient, even if they have never met before. In other words, the anonymous stranger does not fit with the researcher's underlying assumption (and Christensen's) that nursing is a socially determined and accepted institution. If this was not so, then the nurse and client would indeed be strangers, having no knowledge at all of the purpose and expected behaviors of the other. The discussion of the role of stranger is useful at an illustrative level, rather than something that can be reliably used to determine the characteristics of the concept.

The second major problem in this chapter is the researcher's tendency to perceive *anonymous intimacy* as a single paradoxical concept. The parallel is trying to understand something in two dimensions when it is in fact a three dimensional object. Part of this is because the researcher is still inclined to regard the process as concept clarification and analysis - trying to define the boundaries and attributes of a single phenomenon - when in fact it was becoming increasingly obvious that the concept is not a single phenomenon - it was a description of a particular scene in nursing. A scene consists of many concepts and observations about how people perceive, interact, and act, and each of these concepts or observations may be based on a specific assumption. *Anonymous intimacy* needs to contain ranges, varieties, and dimensions of aspects of the phenomenon. Therefore, it is three dimensional. There are sufficient clues in this chapter to suggest that a cognitive leap toward regarding *anonymous intimacy* as a model would be more productive, but this does not occur. The researcher continues to conclude that there are a variety of perceptions of a particular aspect of the phenomenon, but there is insufficient support to select any particular one. *Anonymous intimacy* needs to be regarded as a model in which each of the assumptions about how people interact using public and personal roles, which are influenced by the characteristics of the environment, personal needs, and general tendencies, result in an interaction in which there is some type of individualized and personal contact. The perception of intimacy is thus dependent on whether the nurse and client perceive the interaction as based on roles or recognition of the personal self. If this is achieved, then the absolute definition of intimacy lessens in importance, and the way nurse and client choose to perceive each other increases in importance in terms of producing a

relative feeling of intimacy, privacy, or anonymity. The difference would then become the level of involvement and the intensity of involvement.

These criticisms do not imply that the work to date is wasted, merely undirected. There are indications that progress is being made in determining some aspects of the phenomenon. The context of role guided behavior is useful in understanding how intimate action can take place on the basis of the social sanction of nursing, without depending on the personality assuming that role. However, the central problem remained: role guided behavior is still inadequate to explain how meanings about intimacy, control, and appropriate behavior are transmitted through language or other forms of communication. There is a gap in terms of explaining how role guided behavior based on the social sanction of nursing, allows interaction to be negotiated in a manner that is so natural and easy that it is not noticed either by nurse, client or external observer. The researcher does start to address this, in a disorganized manner by recognizing that there must be an intrinsic assumption of interpersonal competency in nursing to enable socially sanctioned closeness and privacy. In other words, the researcher believes that nurses should possess the interpersonal skills to facilitate whatever type of communication the client may present to, or require of, the nurse. Unfortunately, the researcher also concludes that how this occurs, other than general attending, respect, listening is not clear. Christensen (1990) does provide clues in her categories concerning "face" and presentation of self image, but these remain, both in her work and the present work, unconnected. Gross social communication skills are inadequate in explaining how interactions are negotiated. The key mechanism, therefore must be an intrinsic aspect to all of these communication skills. The issue that now arises is how nurses and clients resist close communication or invasion of personal boundaries while still remaining respectful and courteous toward the other.

Related to the ambiguity of this mechanism of negotiating interactions through shared symbols of meaning, language, and communication, is the researcher's consistent inference that it is the nurse who generally controls these interactions in terms of probing of the other, or selection of the appropriate response. As indicated earlier, this may not necessarily be correct. Nurses are highly skilled at interpersonal communication, however, this should not imply that clients are not just as competent in social interaction. It is possible that clients do indicate their preference - to avoid or invite closeness - in interaction, and nurses concede to this. The issue still remains; how is this negotiated in social interaction, and how does it effect intimacy and anonymity?

In the next stage of this work the researcher needed to change track significantly. The analysis does not depend on clarification of meaning from among multiple contradictory

meanings of established concepts, but synthesis of a multi-dimensional model. This is not the same as attempting a simultaneous concept analysis in which common attributes and factors are identified among similar or related, but essentially parallel concepts (Haase, Britt, Coward, Leidy & Penn, 1991). This approach, applied to *anonymous intimacy* refers to trying to discover how a seemingly self contradictory statement can be proved to be true (Brown, 1993) by identifying the relatedness of the paradox. *Anonymous intimacy* is clearly not a single concept, so a mind set change is required to synthesize and extend the meanings contained in the two words used by Christensen (1990), the meanings throughout her model, as well as the meanings provided in the literature, to build a small sub model that describes a particular or range of nursing relationships.

IV. POLITENESS AS A FORM OF VERBAL DANCE

The real advances in clarifying *anonymous intimacy* started to occur when the researcher was able to begin viewing *anonymous intimacy* as a multi-dimensional model. This allowed flexibility in thinking about forms of intimacy, depending on the desire of the individuals in terms of interaction, the priority need within the interaction, and the ability of nurse and client to willingly manipulate their role/personal self responses to the other. The variable that enables much of this to happen is one of the most elemental aspect of social interaction - something that is often noticed only by its absence, and the difficulties caused by this absence. The concept is *politeness*, the way in which we treat others with courtesy and consideration; the good manners used in almost all social interactions (Brown, 1993). Politeness is a cultural and social universal activity. It is used primarily to ease social interaction, by providing a ritualistic form of verbal interaction (for example, imagine how a supermarket cashier asks if that is all the purchases you wish to make, and how you respond). It provides a bridge to cushion the stark nature of the transaction - swapping goods for money. Politeness provides a means for covering embarrassment, anger, or fear in situations in which it would not be to one's advantage to show these emotions - either as a reflection of one's self, or because of the reaction of the other. It is a way of inviting intimacy, or by increasing the formality and social distance between people, by respectfully and courteously, but nonetheless firmly resisting advances by the other to become more personal and friendly.

The most important feature of politeness is that it is virtually an unquestioned aspect of our lives. We are polite, we expect politeness, and the consciousness of politeness is often the decision to refuse or reduce it. Politeness is a form of verbal dancing with another person in social interaction. It is one of the processes in negotiating how two people wish to perceive and relate to each other. In nursing encounters, politeness is a way of allowing a nurse and client to be respectful and distant; or private, though not involving the secret personal self; or intimate with another person who is virtually a stranger, but who can respond in the way that meets the other's human needs.

This is the missing key in the discussions thus far, although it should be noted that politeness has been hinted at in various ways. The first clue is the fact that *anonymous intimacy* has consistently been regarded as a normal and virtually unconscious feature of nursing social interaction; so the integrating mechanism must be something that is also so rudimentary that it was overlooked in Christensen's (1990) observations, and the researcher's theoretical conceptualizing. The second clue is that politeness is one of the primary verbal ways in which nurses show respect for a client, and which may be quite

separate from their actual personal liking for the person. The terms of address used by clients is the third clue. Use of impersonal pronouns, or avoidance of calling nurses anything even though these nurses may be identifiable by name is not a matter of identifying with nursing rather than individuals so much as a politeness form of showing respect to the whole of the group of nurses, and simultaneously avoiding showing disrespect, or singling out nurses who do not meet the client's expectations. Within nursing encounters, the same approaches to addressing each other is a way of maintaining or manipulating the degree of formality and intimacy. Calling someone "Mary" is informal and friendly. Calling the same person "nurse" is formal, but still socially correct - respectful but impersonal. Referring to the same woman as "you lot of nurses" or "all you nurses" or just "you" is the most distant, bordering on rudeness, but mediating the total lack of personal -ness by associating the person with the larger, liked group of nurses.

This section is the introduction and background of the model of the *Dance in Caring*. It provides an overview of the theory of politeness which is the basis for the model.

Background to the concept of politeness

Nurses spend a great deal of energy on attempting to uphold and respect their clients sense of dignity and autonomy in nursing interactions. Politeness and courtesy are a fundamental dimension of nursing interaction. Nurses are highly skilled at being tactful, gentle, yet firm and empathic in the multitude of interactions with clients. A nurse's communication manner may be the key to drawing a client out to discuss sensitive health issues. Conversely, a direct, but still courteous manner might serve to control another client's inappropriate emotional outbursts. Using behavior associated with a "professional attitude or manner" maintains social distance from the other, yet can still convey concern. All of these attitudes are communication strategies of politeness, part of the interpersonal aspects of language in social interaction. Yet, for such a fundamental attribute of nursing, there is little research to investigate what strategies of politeness are used to facilitate or constrain nursing interaction. The purpose of this section is to provide a brief overview of the model of politeness in order to present the background for considering how politeness may fit into the phenomenon of *anonymous intimacy*.

In all social interaction, there is an inherent risk of threatening our own, or our partners' sense of personal social value. As socially competent actors, we have a large repertoire of communication strategies to protect both ourselves and others from the various inconveniences, embarrassments, and humiliations that are posed to our sense of desirability and autonomy (Brown & Levinson, 1987, Leichty & Applegate, 1991). The politeness principle is also important in trying to explain *why* people are so often indirect in

conveying what they mean (Leech, 1983). The model of politeness is a major dimension of social interaction, originating from Goffman's (1967) concepts of face and face-work in projection of one's identity.

Face, according to Goffman (1967, p. 5), is the "positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact". Face is a social construct to describe the public image of ones self that results from the communicative strategies used to create, maintain, or challenge such an image. It is pertinent only during social interaction, as it is a social rather than a psychological construct (Holtgraves, 1992). According to Goffman (1967), face does not reside in an individual, but in the flow of events in an encounter, as a condition for interaction rather than a goal of interaction. This constraint allows interactants to be self regulating participants in interaction, and to sustain social order through the ritual of face-work. As face can only be given by others, it is in each persons interests to attend to the other's face which in turn supports one's own face. Face-work is part of the basic rituals of every day social interaction.

Goffman (1967) conceptualized face-work as two distinct rituals; avoidance rituals and presentation rituals. Avoidance rituals proscribe what one should not do in terms of violating the other's territory or face. This includes actions such as impinging on the other, drawing attention to other's faults, and introducing threatening or personal topics. Presentation rituals are those intended to affirm and support the social relationship by expressions of solidarity and appeals to the others sense of desirability, through actions such as invitations and compliments. Face-work may be used to prevent potential, mitigate current, or correct past face threats in social interaction. Most people are fluent at both using and recognizing attempts to avoid particular topics or use of ambiguity, in-directness or accounting (apologizing and castigating one's self for actions), in conversations with others.

Brown and Levenson's (1987) theory of politeness is an extension of Goffmans work, originally verified across three languages. The model was first devised in 1978, then revised in 1987. Face-work is re-conceptualized as politeness, a universal aspect of social interaction. Brown and Levenson (1987) assume that all socially competent members of a society have two related aspects of the public image s/he wishes to claim; a negative face, the basic want or desire to autonomy and freedom from imposition and freedom of action; and a positive face, or a positive consistent self-image or "personality", which includes the desire or want to be approved of, liked, understood, and appreciated. Face is mutually vulnerable and emotionally invested, so that it can be lost, maintained, or enhanced in

social interaction. Brown and Levenson (1987) argue that this mutual vulnerability means that people will tend to cooperate - and assume each others cooperation - in constantly attending to, and maintaining face in interaction.

Threats to the other's negative face may include those acts that indicate that the speaker intends to impede the hearer's freedom of action, through orders, requests, suggestions, advice, remindings, threats, or warnings. Negative threats may also include those acts that place the hearer in the position of incurring a debt toward the speaker as a result of offers or promises. Threats may include indications of coveting; acts suggest the speaker's desire toward the hearer or hearer's belongings, necessitating some action to either protect, or relinquish that object of desire to the speaker. This would include expressions of envy or admiration, compliments, or strong negative emotions of hatred or anger. Expression of envy or admiration requires some kind of response - to accept and thank the speaker, or to deny and resist the compliment or comment without implying insincerity on the part of the speaker. In addition, there may be some obligation to reply in kind. Thus threats to one's negative face involve the desire for autonomy, of territoriality, and of independence in thought and action.

Positive face is closely aligned to the basic humans needs of esteem and need for control, the feeling of competence about one's appearance, intelligence, and general ability to cope. It is supported by expressions of understanding, affection, solidarity, and positive evaluation or formal recognition of one's qualities. Positive face is threatened by expressions of violent negative emotions, contradictions, disapproval, disagreements or criticism, irreverence, mention of taboo topics, and blatant non cooperation in an activity (Brown & Levenson, 1987; Lim & Bowers, 1991).

It is possible to threaten one's own face in the same speech act that threatens the other's face. Offending one's negative face occurs through offering excuses, accepting offers and unwilling promises, and responding to the other's *faux pas*. Threats to one's own positive face range from apologies to accepting compliments. Positive face is also threatened by breakdown of physical control over one's body in situations of bodily leakage, stumbling, falling, self humiliation, emotional leakage, or poor control over emotions. Threats include acting stupidly, confessions or admissions of guilt, and ignorance or responsibility for having - or not having - done something or knowing something, (Brown & Levenson, 1987).

For example, the simple act of making a request may contain threats related to imposing on the other (threat to other's negative face), making the reply reflect upon his/her positive face (other's sense of desirability or use) as well as the speakers positive face (threatening

own positive competence face by having to make the request). The request threatens the speaker's negative face, as having the request fulfilled now puts the speaker in a position of gratitude, an obligation that may need to be returned. The act of making a foolish comment or a mistake threatens face through having to deal with the embarrassment (both parties positive face and hearer's negative face as obligation), correct the mistake (threat to positive face and negative face), and account for the mistake. In these brief examples, politeness is apparent not only in the "content of conversation, but also in the way conversation is managed and structured by its participants" (Leech, 1983, p.139).

It seems as though almost every verbal action imaginable contains some threat to either the self's or the other's desire for autonomy or desirability. The point though is that these threats are not perceived as such because the speaker employs politeness rituals and strategies to soften the effect of the threat. They tend to be so well established in social interaction that it is impoliteness that tends to illustrate the use of politeness. Imagine a stranger approaching and demanding "give me the time", or a colleague who is working in the same room with you stating "close the window", or your guest saying at the dinner table "pass the salt". Now, rephrase those requests and commands. A stranger might approach and ask "do you have the time?", an ambiguous statement that implies both a question of possession (do you have a watch with the time of day), to which you do not have to respond affirmatively (you can deny possessing a watch), and a tentative, indirect request that you share that information with the stranger. In this way, the stranger's imposition on you is minimized, and any threats to face are veiled through ambiguity.

Imagine how different your response would be if your colleague said "Is it cold in here?" or "would you close the door for us? I am cold". This way of phrasing a request indicates that the colleague is willing to find out how you feel about the temperature, suggesting solidarity, or the possibility of you both being cold; therefore your action is on your behalf, benefiting you just as much as your colleague. On the other hand, should you reply that you do not feel cold, the statement "Is it cold in here" can easily be rephrased "I must be getting a chill", "I am sitting in a draft" to minimize any implied threat by you that either the colleague has made an unjustified request, or that your colleague is not able to manage his/her own warmth needs by him/herself.

In the third example, if your guest asked "would you pass the salt, please", or "could you pass the salt", or even "is there salt on the table?", you would consider the request to be adequately polite. "Would" is ambiguous, allowing you latitude in your response - "yes", "No, you do not need salt"(a somewhat impolite response). "Could" is even more ambiguous, it is not assuming that you will pass the salt at all, it is at the level of finding

out if it is possible for you to do so. A statement about the immediate availability of salt on the table is the most polite: there is a veiled request that salt may add to the flavor of the food, which implies that the food has not been adequately seasoned by the cook - a threat to the cook's competence and skill. The ambiguity also protects the host who may have inadvertently forgotten to place salt on the table - although an out is available should the host reply "We do not use salt here".

All of these examples are very common. Most people will experience those, or similar ones in everyday interactions. Perhaps in reading them, it will be somewhat of a surprise to find that these normal rituals are politeness strategies to mitigate specific threats to the speaker's and hearer's face. These examples have been used to illustrate some of the politeness strategies used in social interaction: solidarity, approbation, and tact (Lim & Bowers, 1991).

Politeness strategies

Threats to face are ubiquitous in social interaction, so socially competent people must have means for performing face threatening acts while still maintaining each other's face. As the weight of the threat increases, there is a tendency to use more strategies that show higher degrees of politeness. It is postulated that negative politeness is more polite than positive politeness (Brown and Levenson, 1987;Wood & Kroger, 1991). The research on politeness strategies has indicated, that this is not always the case, as people use complex combinations of positive and negative politeness in order to simultaneously minimize the threat to negative face (autonomy) and, at the same time, promote positive face (desirability) through expressions of respect and affection (Lim & Bowers, 1991). Conversation is rarely unifunctional - a speech act, whether a single statement or a series of turns, is generally meant to be multifunctional, to address several threats and goals.

Face work refers to the different ways people mitigate or address face threats. There are different types of face-work for different types of face wants. *Solidarity* is the term used to describe the approach based strategies oriented toward satisfying positive face wants of fellowship and belonging. Solidarity is addressed through agreement, sympathy, cooperation, and through use of in-group identity markers (Lim & Bowers, 1991). In the example of a colleague wanting the window opened, making a requests that implies that the hearer also has a vested interest in opening the window, is an appeal to solidarity ("will you open the window for us). Imposition is minimized as the action is presented as something for the well-being of the larger group.

Approbation addresses competence face wants by showing appreciation of the other's general abilities. It is characterized by efforts to minimize blame and maximize praise of the

other through expression of compliments of abilities, and understatements of inabilities or unsuccessful performances. It is an approach based strategy that appeals to one's sense of competence (Lim & Bowers, 1991). *Tact* is the avoidance strategy addressing the autonomy face, by indicating respect for the other's freedom of action and autonomy by giving options, being indirect or tentative. Tact is the predominant strategy in the way the dinner guest asked for salt, or the stranger asked for the time of day.

These three strategies are in fact super strategies that encompass a wide variety of micro, or more specific politeness strategies. Brown and Levenson (1987) postulate that these strategies form a hierarchical continuum of overall politeness, or extent to which face concerns are encoded. For example, using the want to close the door of a cold room, the most impolite way of making a request, and the most threatening is a direct order, "Shut the door" which conveys no attention to face. There is no respect shown toward the right to autonomy, or freedom of action or choice in this demand. There is no suggestion that the action may be for the hearer's benefit. Rephrasing the same intention - to close the door - in the most polite way, is also the least threatening manner by avoiding appearing to make a request at all. Avoidance strategies use extreme ambiguity, or "off the record" hinting; "it seems cold in here". The speaker hopes that this vague comment will be interpreted in a series of steps; is it cold in here? The speaker must be feeling cold. Should I offer to close the door?

Between these extremes are strategies that emphasize positive politeness face wants and minimizes negative ones. This hierarchy has not always been supported through research (Lim & Bowers, 1991; Lim, 1990). Other researchers have suggested that quantification and ordering is inappropriate and ineffective given the infinite complexity of social interaction (Penman, 1990; Craig, Tracy, & Spisak, 1986). The conclusion, advised initially by Brown and Levenson (1987), is that the politeness model should be reserved as an interpretive framework, used to make sense of a wide range of examples of language usage's that would otherwise remain puzzling. Appendix B provides an overview of one study in which micro strategies of solidarity, approbation, and tact were ordered into a general hierarchy. Lim and Bower's (1991) research is one of the most recent comprehensive studies to provide some indications as to how the micro strategies may be ordered. For example, high solidarity may be indicated by expressions of friendship or empathy, and low solidarity by expressions of exclusion. High approbation includes admiration, support, and low approbation is expressed through resentment, ridicule. High tact is shown by imposition sharing , exploring the possibility for the other to volunteer (so as to avoid an order), and low tact is demonstrated by use of direct requests but with the

addition of conventional politeness markers, such as "please", invoking obligation and orders.

The degree of face threat

Consistent with the notion that face is part of the interaction rather than a quality of the individual, is the idea that the threat posed by an act is determined by the context in which the act occurs rather than the act itself. Brown and Levenson (1987) identify three variables affecting the degree or weight of the threat; the absolute amount of imposition of the act, the position that the speaker has over the listener, and the social distance between the speaker and hearer. It is important to note that these variables, according to Brown and Levenson (1987), are not actual rankings of distance, power, and threat, but only the interactants perception of the amount of distance, power or imposition. The absolute amount of imposition of the act is self explanatory, determined by the individual's perception of how the act threatens his/her wants for autonomy and freedom, and sense of self esteem and desirability.

According to Brown and Levenson's (1987) formula, the weight of a face threatening act for a person increases as social distance increases, as speaker's power over the hearer decreases, and as the absolute size of the imposition of threat increases. In other words, a request may be more threatening if it is asked by an acquaintance who is one of your subordinates, and if it baldly ignores your autonomy or competence wants. Unfortunately these hypotheses are somewhat inconsistently supported through research.

Strong support has been found for the power variable. Most studies demonstrate that as speaker power increases, politeness decreases (Holtgraves, 1992). Leichty and Applegate (1991) and Baxter (1984) found that, consistent with the model, as speaker power increased, politeness tended to decrease, and that as legitimate power decreased, politeness increased. These researchers indicate though that it is not the relative status of the actors that is important, but the specific legitimacy that the speaker has for a particular act. For example, a teacher has general power over a student, and may legitimately request the student to rewrite a paper, but may not ask the student to wash the window. If this was requested, the teacher would utilize far more politeness than s/he may choose to do in asking the student to rewrite a paper. In nursing interactions, a nursing assessment provides the nurse with the legitimate power to request information about the client's private physical, emotional, sexual life, but this legitimacy does not extend to advising the client on financial investments. Going further, in a hospital, the ordering and division of work may mean that the client has the legitimate power to ask a nurse to straighten the bed

or close the window, but not to polish the floor, or wash the client's clothes. Thus speaker power is act-specific and not a simple relationship property.

The effect of the variable of social distance has been controversial. The Brown and Levenson (1987) model hypothesizes that decreased social distance (a friendship) will lead to decreased politeness. Some researchers have found greater politeness in more distant relationships (Holtgraves & Yang, 1990) as the theory predicts, while others, such as Leichty and Applegate (1991) and Baxter (1984) found to the contrary; increased familiarity leads to increased politeness. However, in these two studies, the authors noted that social distance should be differentiated into familiarity and liking. If distance is seen as familiarity, then the research supports the theory. The argument is that in unfamiliar relations there is an unknown potential for aggression, so politeness is used as a means of signaling lack of aggressive intent. This is less of a concern among familiars. However, when distance is equated with both familiarity and liking, the research fails to support the theory (Holtgraves, 1992).

Multiple goals in discourse

Although attending to face wants tends to be a social norm, face respect is not an unequivocal right. It is not generally required that one *fully* satisfies another's face wants, and there are many social situations in which face is routinely ignored in the interests of urgent cooperation or efficiency. There are at least three objectives to consider when choosing an approach; the desire to do the face threatening act, the desire to communicate effectively, and the desire to satisfy at least some of the hearer's face wants (Brown & Levenson, 1987). It is also obvious that there are generally *multiple* goals in social interaction. If the instrumental goals take precedence over the social goals, then face-work will be reduced. For example, courtesy and politeness in a cardiac arrest situation may be kept to a minimum, requests for particular actions being expressed as bald commands because the priority is resuscitation, not saving the face of the team working on the victim.

However, some of the recent research in politeness in social discourse indicates that the politeness strategies are so abundant and occur in such variety that they can be mixed in varyingly skillful ways to accomplish several goals through multifunctional discourse (Craig, Tracy, & Spisak, 1986; Ragan, 1990; Aronsson & Satterlund-Larsson, 1987). In addition, this complicates interpretation of politeness strategies, as each act may be directed to one or more social or instrumental goals. This complicates attempts to sort politeness strategies into a hierarchical form using specific objectives, goals, and variables of power, social distance, and absolute degree of face threat. The conclusion is that the politeness model should be used as an interpretive to understand a range of language use. Studies of

naturally occurring conversations - including courtroom discourse, medical consultations, and nursing consultations - show how the model can be used to interpret aspects of communication that would otherwise remain ambiguous, and to further refine understanding of communications directed to other goals (Shurpin, 1989; Aronsson & Satterlund-Larsson, 1987; Penman, 1990).

Politeness as forms of address

The way in which one person addresses another and is, in turn, addressed by the hearer constitutes a pattern of great regularity (Wood, Kroger, & Leong, 1986). According to Brown and Levenson (1987), the use of honorific titles may be linked or determined by the introduction of a face threatening act. All languages encode deference in generalized forms of address for strangers and unfamiliars. Use of honorific titles are indications or automatic signals of predetermined social standing. Brown & Levenson (1987) also suggest that different forms of address are typically strategically used to soften face threatening acts by indicating an absence of risk to the addressee. Wood and Kroger (1991) suggest that forms of address are more basic in that their use opens communication and sets a particular tone for the following interchange, as well as establishing the initial relative power and distance of speaker and hearer.

The use of impersonal verbs and pronouns is an alternate to use of honorific titles when dealing with face threatening acts. The use of the plural of "you" and "I" provides a conventional "out" for the hearer as it avoids singling the hearer from the larger group. (Compare your preferred interpretation; "you nurses are all so kind and lovely. It is a pleasure being looked after by you", and "You nurses seem to be so busy nowadays that you do not seem to have the time or interest in just sitting and talking to us patients anymore"). In this way, the speaker gives the hearer leeway to interpret the speech act as applying to the group or to him/her individually (Brown & Levenson, 1987). The authors note that this conventional manner probably does not *actually* do this, although it conveys the desire of the speaker to offer this tribute while still fulfilling the practical needs of clarity and directness in speech. In other words, the "You" (plural), is motivated by exactly the same wants that account for conventional in-directness. Brown and Levenson (1987) also postulate that a person's social status is fundamentally linked to membership in a group, so to treat persons as representatives of a group rather than as relatively powerless individuals would be to refer to their social standing and the backing they derive from their group. Thus the use of plural "you" shows respect to the hearer.

The use of forms of address as expressions of politeness is a growing area of research. Socio-linguistics researchers concentrate on the commonalties and differences within and

between languages, examining why languages often have both a formal-polite and informal-intimate pronoun of address (the French "Vous" and "Tu"). Braun (1988) for example, supports Brown and Levenson (1987) in that the use of a third person or impersonal form (he/her, him/her) is a less direct appeal to the hearer than a second person singular pronoun (you). It is a form of avoidance of direct address and an attempt to keep a distance from the hearer.

Wood and Kroger (1991) too, found that maintenance of negative face - freedom from imposition and sense of autonomy - requires achievement of distance. Vertical distance is created by deference, the acknowledgment of lack of common status. For example, "Your Majesty" denotes hearer as the occupant of an exalted, sacred, and remote position, as does various other titles. Horizontal distance between equals is created by mutual deference, for example, two strangers addressing each other as "Mr". Distance can be created also through use of title, but interpreted as impersonalisation (Wood & Kroger, 1991). Denial of individuality by the use of "sir" identifies hearer only as member of a category (all adult males) rather than as a unique individual. Thus the reference to a nurse as "nurse" may, depending on the context, be indicative of respect/deference for nursing, and acknowledgment of social distance (i.e. not friends, but not strangers), or indirect disrespect through distancing and depersonalization (decision not to recognize the person's individual nursing approach). Wood & Kroger (1991) suggest that the use of title and last name by a speaker is potentially two negative politeness strategies - impersonalization and showing of deference.

Maintenance of positive face requires achievement of closeness and common identity (Wood & Kroger, 1991). This is created by personalization and use of identity markers. Mutual use of first name signifies that both speaker and hearer "belong", for example the use of "sister" in feminist discourse. Terms of endearment are ultimate indices of closeness and intimacy (this does not apply to people who commonly use terms of endearment, such as "dear" and "love" in general social discourse. This may be a cultural feature, or inappropriately assumed solidarity. There is, however, a lack of research explaining this particular speech habit). According to Wood and Kroger, use of title and last name shows deference only if it is used non reciprocally - if the speaker in turn is addressed by a more intimate personal form, such as the first name. Use of the first name is potentially positive politeness, an in-group marker which indicates intimacy. If used non-reciprocally, then it can indicate the opposite of deference - condescension - which is a face threatening act to positive face by suggesting that the hearer's worth is less than the speaker's worth.

Wood, Kroger, & Leong (1986) found that when dispensation in terms of forms of address is given in status marked settings, the result is generally ambiguity, especially in highly formalized and ritualized settings. The hearer, invited to use a personal and familiar form toward a distant and more powerful other, may consider this invitation irrelevant and highly inappropriate. The result is often incomprehension. In settings marked by status differences, dispensation may be an invitation to increase intimacy. Aronsson and Sutterland-Larsson (1987) found that in formalized settings, such as doctor-patient consultations, ambiguity, and discomfort were apparent irrespective of either introductions or invitations to use particular forms of address. In fact, both doctor and patient avoided addressing the other in a way that required a pronoun, instead, presenting statements in impersonal and tentative forms.

Although it is polite to ask a nursing client how she/he would like to be addressed, there is an interesting trend toward both inviting clients to address nurses by first name, and for nurses to address their client's by first name. Christensen's (1990) description of how nurses and client address each other suggests that no matter what invitation is given, or what right to address is assumed by nurses, clients often do not respond in a like way. One interpretation may be that clients simply do not remember the nurses looking after them. Another may be that the invitation to call, and be called by first name is inappropriately assumed by nurses. Consistent use of impersonal pronouns, or title "nurse" may be an indication that the client desires more distance and privacy than is implicated in interactions initiated by first name, yet the client still wishes to show respect and appreciation of the nurse(s).

Summary

The notion of politeness is a highly complex system of regulating social interaction. Politeness exists to enable social actors to achieve instrumental goals by assuming and activating cooperation of the other and by mitigating the effects of threat inherent in almost all social action. The concepts of autonomy, self esteem, and solidarity have long been associated with personality, but it is asserted in the model of politeness that the universal desires of negative face (autonomy) and positive face (desire for approval and to be seen as competent), are an integral part of one's identity, but are not the same as one's identity. These face wants are aspects of interpersonal interaction, and, as such, can only be attended to within social interaction. The model proposed by Brown and Levenson (1987) is a highly structured method of determining the characteristics and weight of the threat posed by a particular speech act in terms of threat to negative or positive face want of the other person as well as the self. This calculation is mitigated by the variables of power,

social distance, and the overriding objective of efficiency or politeness. The sum determines the politeness strategies that would be sufficient to satisfy most of the face wants of the other. Politeness is often not a conscious effort - its absence often serves as the only reminder that the social interaction was inappropriate. The hierarchical ranking postulated by Brown and Levenson (1987) has not always been confirmed through research. However, the increasing amount of analysis of naturally occurring conversations is proving valuable as a means of understanding interactions that would otherwise remain a puzzle.

V. THE DANCE IN CARING

The concept of politeness is conceptualized as one of the ways nurse and client negotiate the level of interaction in nursing encounters. As in a dance, there are set moves, advances, retreats, and turns. Sometimes, the dancers keep to a familiar and routine series of steps, other times that pattern is ignored and a free whirl follows. This kind of dance is not as restrained by traditional patterns, so it may be exciting, and there are dangers of toes being stepped on. The partners must be very aware of each other to avoid these mistakes. The same occurs in social interaction. There are times where the conversation is so routine and ritualized that it is almost immediately forgettable, the main concern being the object of the transaction not the participants. Sometimes it may be deeply personal and meaningful. Politeness is one of the verbal techniques that people use to manipulate the level of interaction in terms of social distance to create intimacy/being personal, and formality/being impersonal. Politeness allows these changes to take place without appearing to be impolite, rude, or uninterested in the other person. It is an important way to protect one's privacy in an environment that permits little privacy. This chapter begins with a brief outline of how politeness is conceptualized in this model, followed by the description of all of the concepts in the model of the *Dance in Caring*; the context of the social mission of nursing; the passport that allows nurses to enter client's private spaces, the function of roles in social interaction, and the ability for nurses and clients to choose what will be the focus of their interaction.

Politeness: The rules of the dance in caring and social interaction

Politeness is the core theme in this model of nursing interaction. Although it is not the sole mechanism used in interaction, it is proposed as one of the ways that nurses and clients indicate and negotiate a mutually acceptable level of interaction in terms of social distance (formality and informality), and involvement of self versus role (privacy and intimacy). It is a basic social process to manage one's self image, presentation, and face in situations that inherently contain significant threats to one's desire to appear competent, likable, and autonomous.

One of the fundamental aspects of nursing care is respecting, honoring, and protecting client's dignity, self esteem, independence, and autonomy. This is achieved by attending to client's objective and subjective needs (Cooper, 1993). Within the politeness framework, dignity and self esteem refer to one's positive face, and autonomy and freedom of action refer to one's negative face. Many nursing interactions involve actions that threaten client's face wants. The threats include embarrassment or shame over revelation of something normally kept private (or loss of control over bodily functions), or exposure of emotions

such as pain, fear, or anxiety which may be perceived as an indication of the client's inability to appear in control of him/herself or competent. For example, intensive comprehensive health history or health status interviews and physical examinations or activities invade parts of the physical, social, psychological and emotional self normally not revealed to strangers. Even the fundamental role of health teaching may be perceived as implying that the client's previous or current health or lifestyle practices are inappropriate, unsatisfactory, or wrong - thus the need for teaching. The act of inquiring whether a client needs more analgesia may contain threats pertaining to coping, composure, and control.

None of these activities are meant to be an undue threat or to contain negative connotations about the client. They are an intrinsic part of offering care to another person. Part of nursing's success in caring and helping people is the social skill of the nurse's approach and offering of assistance. Politeness is a natural and often subconscious social process that nurses use to negotiate a comfortable level of social distance and interaction in situations when self disclosure by the client is required as part of the nursing assistance. Self disclosure may be any form of revelation, physical or informational, that the client offers as part of the contract s/he has entered into in order to obtain nursing care. Self disclosure is not always spontaneous; it is carefully guarded. Privacy of self is controlled through managed self disclosure in terms of breadth and depth of disclosure. Appearance of reluctance to cooperate with information probes by the nurse is deflected by the politeness strategies of avoidance, ambiguity, empty explanations, apology, and hedging.

Support for the centrality of politeness in situations of client self disclosure is found in the work of Holtgraves (1992). He argues that client self disclosures raise face concerns for both nurse and client. If the client exposes negative information - for example anti-social habits that are detrimental to health, but adhered to despite health professional advice, admissions of poor cooperation with treatment programs, or even just an expression of a need for help - the client threatens his/her own positive face or the want to be liked and seen as competent. The nurse, in responding to this revelation, is simultaneously placed in the position of having to help manage the clients spoiled identity which is an imposition that can be regarded as a threat to his/her own negative face or freedom from imposition. In this model, it is argued that it is the nursing skill that enables nurses to attend to these needs and mitigate these threats effectively. It is part of caring, promotion of human dignity, and respect for personhood that are the function of nursing.

An individual's perception of the importance of politeness in a social interaction is dependent on three other variables; the perceived importance of the need for efficiency, the need to communicate effectively, and the motivation that each person has to cooperate in

attending to face. If the first two goals are held to be more important than attending to face needs, the interaction will be perceived as rude, uncaring, and uncharacteristic of caring nursing. These types of interactions are not within the concern of this model. The focus in this model is how nurses and clients are involved in caring encounters that have a range of levels of involvement. This is not to imply that all encounters that have efficiency or effective communication as the prime concern are negative interactions. Emergency situations are an example of interactions in which the nurse may choose to use direct commands or orders rather than introducing ambiguity through politeness. The motivation that each person has in attending to face is a factor in this model, although again limited to situations in which there is a decision to use politeness to manage face by manipulating boundaries of privacy. Decisions to be impolite will fall outside the model.

Multiple goals

Politeness allows the interaction to be managed in terms of multiple goals. These goals may include the primary instrumental activity, and related goals, such as offering health teaching; and social goals of self esteem, dignity, and autonomy. Nurses assist in preserving face by helping the client retain as much autonomy, poise, and composure as possible by reducing embarrassment, humiliation, and using tact and indirectness to sustain a sense of autonomy.

The work by Ragan (1990) on verbal play and multiple goals in interaction between a nurse practitioner and her clients, as she carries out gynecological examinations, indicates how important this integrative social skill is in nursing encounters. Ragan (1990) found that the nurse and client collaborate to produce a sequence of play that is extraneous to the medical or instrumental procedure of the exam. This play, through its reliance on tacit social knowledge, helped define the nurse and client as people cooperatively engaged in a task rather than mere technician and technical object. Play sequences were oriented to the non-medical goals, which included joking, shared stories, personal disclosures, teasing, and solidarity (in this instances joking about assumed shared assumptions about menstruation, sex, and the exam itself). Meeting the instrumental goal of the gynecological examination involved some objectification of the procedure, to separate the woman from the examination, as a way to reduce embarrassment. The underlying ability of the nurse was to perceive the woman simultaneously as a person and as a technical object in order to sustain the balance between the instrumental (objective) and social (human) goals. In this particular research project, play functioned to reduce the face threat of the exam by producing a shared, mutually constructed definition of the situation, based on a

presumption and understanding by the nurse of the client's dislike of the examination, and the client's willingness to validate this perspective.

This skill in making contact with another person in different, but simultaneous ways is essential to caring nursing encounters. Van den Berg (1966) expresses cooperation in the human, social goals as *pathic* or affective contact. The objective concern - the activity or task - is the *gnostic* contact; the cognitive nearness with someone who is trusted but who is not involved in the way a friend would be affectively concerned. He likens the difference to a caress and a medical palpation. His discussion of these types of contact between health professionals and patients tends to be related to describing whole encounters or relationships. However, the concepts are definable in terms of the multiple concerns within a single interactions. Thus, in this model, focus on instrumental or objective concerns will be referred to as *gnostic* concerns, and social or human concerns will be referred to as *pathic* concerns.

Cooperation between nurse and client, whether equally mutual, constrained, or directed by one party, forms a context for the disclosure that is about to occur. The way the nurse or client introduces a topic, makes a request, or addresses the other indicates the degree of formality, social distance, and level of interaction desired by each party. Forms of address are used to manipulate distance; to invite or reject a change in level of interaction, to show deference and respect, as well as to indicate dissatisfaction with care through use of impersonalisations. Thus, Christensen's (1990) observation that clients appeared to identify with nursing rather than with individuals, may in fact be an attempt by clients to avoid singling out particular nurses, an attempt to flatter a nurse by attributing a positive trait to all nurses, or it may be an indication that these clients experienced nursing encounters that were indeed immediately intimate, but only on the level of restricted pathic response which was constrained by role guided rituals. Furthermore, the examples Christensen assumed were indicative of a relationship with nursing may be more appropriately defined as clients' polite expressions of a need for inclusion. Solidarity may be expressed through verbal expressions of cooperation (for example, "you go on nurse - I know how busy you nurses all are"), empathy, and character appreciation (for example, "you nurses are all so lovely... this job must be so tough...look what you have to do").

To illustrate, it is proposed that although there are an infinite variety of types of nursing interactions, *anonymous intimacy* refers to the type of interaction in which politeness indicates respect for client's privacy within the interaction, so that the interaction is guided and constrained largely by roles. Interaction is at the level of cooperation in the sanctioned privacy given to nursing in society. Recognition of the other is predominately by role, so

terms of address would tend to be formal and impersonal, so as to maintain social distance and show respect and deference for the other. Thus, outside of those private interactions, the client continues with this level of formality, indicated by not differentiating between nurses, as to do so would be to single one out as better, worse, or different from the larger group of nurses. The nurse also recalls the client based sense of predominance of gnostic rather than pathic contact. Recall cues will be connected to the object of this gnostic contact, associated with the reason for admission, or through association with a feature of the environment (e.g. bed 17). This is not necessarily a negative or undesirable type of nursing relationship - as long as it does not deny recognition of the clients subjective needs.

High use of politeness may be an indication of a gnostic or impersonal service-task interaction. In this type of contact, there is no perception of the other beyond the role and gnostic concern. There is anonymity of person, impersonal approach, and communication activities that are almost entirely ritualized. This type of contact is likely to occur if there is a high desire to protect the client from face threats (such as embarrassment), or if the nurse is unwilling to respond in a pathic manner that involves her private self beyond the role. Social distance is maintained through formal terms of address, or avoidance of address, so that recall of the other will be on the basis of role alone, perhaps even with minimal association with personal characteristics.

A personal relationship that is transposed into a nursing situation may be another illustration of the importance of politeness. The type of interaction referred to here would be similar to being nursed by a friend, or relative. Politeness may be essential to distance each other from the embarrassment caused by being exposed to disclosures of a nature not accustomed to in the normal relationship. There may be familiarity and friendship, but a level of formality, distancing, and objectification will be utilized to deal with the issue. In this situation however, forms of address would tend to be personal (identification first name), as knowledge of the other is based on personal friendship.

It is beyond the scope of this thesis to predict exactly what types of politeness strategies would be used in nursing interactions, the main reason being that complex combinations are used as specific communication need arises. Appendix B contains a condensed version of the types of politeness strategies grouped by face want (Lim & Bowers, 1991). A descriptor list such as this would be the tool used to descriptively investigate politeness strategies in nursing interactions.

Roles in the Dance in Caring: The schema of typicality

In professional relationships, social roles are a mediator between the social structure and face-to-face interaction. This is based in part on the concept of interaction competency

(Stiles, Orth, Scherwitz, Hennrikus, & Vallbona, 1984). Use of social roles facilitates interaction by providing a general understanding of the qualities, characteristics, and services that may be presented and offered within interactions. Roles facilitate efficiency in interaction by constraining behavior in the sense that desires for qualities or services beyond the general bounds of the roles is discouraged. Thus, social encounters that are highly guided by roles will tend to be routine and ritualistic in terms of consistency of interaction.

The concept of roles is also drawn from the idea of *schema* from social cognition theory. *Schema* refers to the representational structures into which memory is organized. Mental representation can refer to a prototype to represent knowledge about types of people or objects, or to a script to represent knowledge about particular events. These pre-existing representations guide the perceptions and processing of new information, and new information modifies these representations as they are interpreted and assimilated (Morgan & Schwalbe, 1990).

The definition of situations is thus tied to the actual course of the interaction. Role schemes, although general and provisional, help with initial definitions and understanding of situations until current experience enables more specific knowledge and understanding. Roles thus may be considered to be shared performance imagery that functions to structure perceptions of social acts, to guide acts to completion, and to make sense of acts in discourse. Social processes are formed as people interact, shape, and adapt to their social environment.

The description of the function of roles in the *Dance in Caring* contains an inherent assumption about the cooperation between people in social interaction. This premise is drawn from symbolic interaction theory. Social interaction is based on cooperation between interactants to achieve a goal or outcome. Cooperation is dependent on a reasonable consensus about the nature of the situation, and the importance and function of common general understandings or *schemas* of health related contexts (Hardy & Hardy, 1988). To act with another to achieve a social objective, according to Couch (1986) "...requires the establishment of reciprocal attentiveness, mutual responsiveness, congruent functional identities, and a shared focus" (p. 119).

In essence, roles are not what people do, nor even the expectations about what others should do in the functionalist role theory sense, but ideas about ways of acting, and recognizing that other's overt acts constitute role performances. The tentative nature of social understandings is illustrated by Schutz's (1971) argument that within a social group, the system of knowledge appears to be sufficiently coherent, clear, and consistent to give

anybody a reasonable chance of being understood. This cultural or social knowledge is taken for granted as a guide to interpreting the social world, and as a precept for actions and as a scheme for expressions.

Much knowledge of social behavior is based on the idea of typicality. This refers to the "recipes" for behavior or typical solutions for typical problems for typical actors. In other words, there is an assumption that if I act typically, I can expect you to act typically in response, and vice versa. These roles or behaviors are designed for common use, so they need not be tested for fitness for the particular individual who employs a particular role. Understandings about nursing and being a patient are derived from the media, contact or interaction with these roles, or with others who have had such contact. This provides a wide range of sometimes contradictory stereotypical or reality based general knowledge (a recent study by Lippman & Ponton (1993) on the image of nursing indicates that most of the respondents reported personal contact with a friend, colleague, or relative who was a nurse, or that they had been cared for by a nurse).

Individuals come to social encounters with a repertoire of both typical responses and a unique response repertoire. One's eventual conduct and experience in situations, relying on general understandings or schemas, are also influenced by the part of the person that is defined in terms of the individual's perception of how others perceive and evaluate him/her. This aspect of the self concept, initially defined through assumption of role related identities, will influence specific patterns of conduct in role motivated encounters. However, although behavior motivated by role guided patterns of conduct may predominate in the initial stages of interaction, so as to give the appearance of a competent performer in the system, individual style and approach is not precluded. The nature of one's self concept and thus unique character will always have the capacity to influence how one will behave in social interaction (Pierce, Meloff, & Harrell, 1992). The determining factor is the individual's particular desires for interaction, or the particular objectives for each particular social interaction encounter.

These objectives or expectations partially reflect the influence of the present situation and the present partner in encounter. For example, Kellermann (1986) suggests that although one might not typically want to exchange intimate information, a specific context does have the capability to initiate a high desire for intimate information exchange. Although a nursing client might not generally tend to either expect or engage in intimate self disclosure, particular situations - such as nursing interactions - facilitate this pattern of behavior. Conversely, if the client's desire is to protect privacy, then she/he will find means to avoid responding to the context stimulated expectations of disclosure response

patterns. However, the other person - the nurse - in the interaction also has an influence on the context driven pattern of behavior; as a constraining or facilitating factor. If the nurse's tendency or objective is to reduce, constrain, or prevent certain patterns of behavior (for example, disclosures beyond those perceived as required for the immediate nursing care), then he/she will use response patterns to constrain the client's current and potential behaviors.

A passport to privileged intimacy

The social sanction of nursing is an important passport that allows a nurse to access the normally very private aspects of a client's life in nursing interactions. The role that nursing has in society is fundamental to understanding how *anonymous intimacy* type situations are created. While it is not the intention in this thesis to present a specific approach, it is important to encapsulate the most important features of my perception of nursing's mission in society. The following passage from Benner and Wrubel (1989) represent both the artful and scientific aspects of the caring service nursing offers to society. The only qualification is that this quote pertains only to illness situations. Nursing is involved in all health events in life, not just illness, and in the community, not just the hospital. To use Christensen's (1990) term *"health related event"* is vague, but perhaps necessarily so. Nurses are concerned with health, of which illness, birth, growth, and death are parts. The researcher's amendments to Benner and Wrubel's passage are indicated in italics.

> ...nurses can and do make a difference in how a person experiences an illness or *health related event*.. Nurses are in the unique position of being able to understand both the disease/ *physiological* experience and the meanings that the patient brings to that experience. As a result, nurses can help shape the illness or *health related* experience for the patient by guiding, interpreting, and coaching. .... nurses also establish a healing relationship by helping the patient mobilize hope and embrace recovery by appropriating available social, emotional, and spiritual resources. Nurses act as cultural mediators and serve as coaches for patients, making that which is strange and foreign approachable and interpretable (Benner, 1984) (Benner & Wrubel, 1989, p. 62).

This social sanction of caring provides a passport to the intimate and private aspects of people during virtually every emotional event imaginable. Benner and Wrubel (1989) refer to this as the *privileged place of nursing* (p. xi), Christensen (1990) simply as the learned specialized assistance that helps minimize the impact of a health related event. In this framework, passport refers to the sanctioned right conferred on nurses to enter or invade people's private physical, emotional, and psychological space in order to be able to offer nursing care. The notion of *Passport* is drawn from Sparrow (1991), who identified the wearing of uniforms as one visible passport to accessing nursing clients. The term passport

in the context of the *Dance in Caring* involves more than the identity markers - uniforms, name badges, instruments - that provide a recognizable indication of the probable behaviors and attitudes of the nurse. The passport is the social recognition and acceptance of nursing in caring for people in times of health need. It is a passport to initiate interaction between people who are otherwise strangers. The extent, however, that interaction involves contact that is pathic or gnostic in nature, is still fundamentally determined by the goals of each person in terms of efficiency of instrumental activity over pathic contact, self exposure, need for privacy, and the desire to cooperate in attending to face wants.

The context of nursing.

The second aspect of the passport to privileged intimacy is the context of nursing, or the particular set of conditions or location of events within which the action strategies occur (Strauss and Corbin, 1990). These include assumptions about how nurses and clients cooperate in nursing care, which includes implicit assumptions that the client will accept impositions as part as the care, and a corresponding obligation for nurses to regard and treat this imposition in the most sensitive way possible.

Client cooperation with health goals: Imposition and obligation.

Accepting nursing services indicates acknowledgment of the need for nurses to impose upon the client's privacy in order to offer nursing care. However, this obligation is counter balanced, and constrained by the corresponding obligation on the part of the nurse to meet the clients needs - both gnostic or instrumental (the nursing activities) and pathic or social (which includes sense of esteem and autonomy). The manner in which a client decides to accept the impositions involved in nursing care, and the way a nurse chooses to respond to the obligation to use sensitivity in caring for the client, ultimately determines the nature of the nursing encounter. The client and nurse each have the ability to respond to the other using predominately role guided responses, so the public persona of client or nurse is presented rather than the personal aspect of the self, or to respond in a more pathic manner - sharing aspects of the private self necessary to seek or offer care.

Offering nursing service is based on an assumption of cooperation, although nursing clients are free to choose whether or not to cooperate with specific nursing requests. Burgoon, Birk, and Hall (1991) note that in doctor-patient relations, the socially defined expectations within this relationship provides doctors with a substantial variety of means to gain compliance, very often because the effects of noncompliance may result in worsened illness or death. The concept of outright sanctions for noncompliance fits very uncomfortably within a nursing framework - not only because of the nursing assumption of freedom of choice and the nursing function to be to supportive rather than controlling - but

it must also be acknowledged that nursing does have a vested interest in monitoring indications of reduced cooperation. Attempting to encourage cooperation is part of a nurse's skill. Trying to persuade someone involves a variety of techniques to foster agreement without appearing restrictive or disrespectful to the client's right to freedom. One of the most important strategies in this is politeness.

Directly opposing evidence of reduced or selective cooperation is very often inappropriate in nursing encounters especially as it is not always possible to discover the cause of such behavior. However, indirectly, and in a way that strives to avoid offending the client, a nurse can identify, comment on, and redirect inappropriate behavior. Consider, for example, the issue of smoking preoperatively. It is the norm in pre-operative preparation to warn clients of the dangers of smoking, and in particular, smoking in the 24 hours prior to surgery. How should a nurse react when he/she discovers that the client is intending to - or just has, smoked a cigarette? The most obvious way would be to clearly and unambiguously state that this is not advised, and that the client should not continue in this manner. This response has the potential to convey not only an ignorance of the anxiety and fear that the client may be experiencing, and denial of the clients usual coping strategy, but also an intention to ignore or devalue the client's freedom of action. The nurse certainly has the right to do this - it is part of the client's pre-operative nursing care. This is, at best, a brusque approach, at worst, simply impolite. It is likely that, in most instances, the nurse will state the request to discontinue or avoid smoking in such a way that the client's sense of autonomy and self esteem are protected as much as possible. The nurse will convey, using a sensitive polite approach to the request, that (particularly in hospital contexts), the client's current situation is "not the ordinary world of human experience" (Cooper, 1993, p.25). This situation, which involves the client's agreement to relinquish control over many normal functions and activities in life, may also be the source of a distressing degree of anxiety for the client. This anxiety may occur in non-hospital contexts if the health related experience is such that the client has insufficient knowledge or experience upon which to draw. It is nursing's function to assist the client through the experience by guiding and interpreting, building, and extending the clients resources.

The politeness techniques the nurse might use range from indirectness and empathetic understanding (especially if the nurse smokes or has smoked) which would result in "I know what it is like" (an expression of solidarity), to distraction and veiled suggestions for compensatory actions "Would it help if we locked them away", and the least desirable action from health stance, avoidance or overlooking of the issue.

Continued non cooperation - behavior that jeopardizes the client's health status - may be addressed in the same manner. Aronsson and Satterlund-Larson (1987), although in a medical context, describe clearly how the institutional authority structure makes expression of resistance for patients in medical consultations difficult, and how the doctor often employed circumspect communication maneuvers to approach, address, or avoid particular topics of concern. The use of politeness strategies by both doctor and patient, the researchers concluded, seemed to be a way of mitigating threat and to soften perceptions of the doctor's control over the situation and patient behavior. Thus, in nursing interactions, nurses are motivated to foster at least a minimum level of cooperation through communication tactics that persuade but avoid overwhelming threats to the client's negative and positive face wants.

Distance and nearness: An alternative level of reality

One of the underlying assumptions in this model, that helps explain the reasons why people choose to orientate to the other's face needs, is the decision about the level of interaction that is comfortable for the person. The level of interaction - an entirely service-task gnostic encounter or an intensely personal pathic encounter - is based on a particular level of illusion about the real, personal and private, or public and assumed persona of one's self and the others with whom one interacts. This perception of the involvement of the self or assumed role in social life helps confine attention to what is appropriate, meaningful, or consequential, as well as helping determine the frame, or the degree of seriousness that is to be attached to an event. There are three levels of illusion: the "pretend" reality of games, sports, parties, and ceremonies; the "alternative" reality" of occupational worlds and ritual; and the "overriding" reality concerned with the deliberate efforts to change or defend definitions of the situation or the rules of the game (Burns, 1972, cited in Hare & Blumberg, 1988).

Nurses deal with what is both sacred and profane in society; events that are simultaneously loved and cherished, and loathed and hidden. Nurses need a large repertoire of interpersonal skills to perform effectively in a range of situations in which there is frequently a need to distance the person from the need, or the person from the action - or a melding of the two - sometimes in the same encounter. Politeness is a social ritual in which roles can be used to guide, facilitate, and restrain behavior. Thus, much interaction in nursing is suggested to at least initially occur on the "alternative level of reality". The model of the *Dance in caring* is largely situated within the world of occupational roles.

The initial importance of nursing is the service, although appreciation of the service may not always be intimately associated with the individual offering the service. The rituals of

interaction, the perceptions of what and how nursing "is", is one way of interacting if the client wished to limit his/her involvement or knowledge of the person offering the service. To illustrate, it is perfectly possible to buy groceries at the supermarket, to exchange a few pleasantries with the cashier, even to finding out how the cashier's day has been, without really having any perception of the person who is the cashier. This is a service-task based interaction. Individualities do not matter. It is a normal feature of daily life. In nursing, the situation is different. The issues and concerns being of greater importance, but the principle, the ability to restrict involvement to a ritualistic level of nurse-client roles is still possible. One of the ways this is achieved is through politeness, and one of the reasons it is done is to protect one's sense of privacy.

Coorientation

The social sanction of nursing to care provides a passport to enter into client's private spaces in order to offer nursing assistance. This passport however, does not automatically mean that the nurse will perceive all concerns the client may have, or that the client will share those concerns. Furthermore, even if the concerns are shared, the nurse or client may choose not to address them. For example, the nurse may choose to initiate an interaction characterized by attention to the gnostic concern, avoiding noticing the pathic concern that may be associated with the gnostic issue. If this attention is contrary to the clients apparent desire, then the nursing interaction may be perceived as uncaring. There are times, however, that a client may want this privacy. In this instance, even though both nurse and client are aware that there are pathic needs, both cooperate to avoid heeding them during that particular interaction. The interaction uses ritualized patterns of behavior and responses to direct and restrict attention to the gnostic concern. There are times, that the pathic concern is of equal or more importance to the client. If this is recognized and accepted by the nurse, then *coorienting* occurs to create an environment in which the client feels safe, and the pathic issues may be faced.

Coorientation refers to the choice of nurse and client to attend to the client's pathic needs in a manner that has the potential to transcend role guided rituals. The resulting transaction is characterized by trust, concern, and openness to the client's needs. Coorientation, drawn from Kellerman's (1986) work, is described as the ability for partners in interaction to perceive the information characteristics of one of the persons in a similar manner. In other words, nurse and client are working together to establish a mutual perception of the pathic concerns being expressed by the client. Coorientation is motivated by the willingness to connect with some personal aspect of the other in order to create a specific sense of alliance, transactional privacy, or intimacy. Maintaining highly ritualized role based

interaction is no longer sufficient to meet the demands of the situation, as the pathic concerns require each person to be able to use the *self* to meaningfully relate.

The emergence of coorientation in an *interaction* signifies a willingness to change the level of interaction, but not an unconditional agreement to use all aspects of self. As Ingram (1991) notes, this type of interaction has limits and boundaries just as purely role based transactions do. The nurse may still use the boundary of nursing to restrict the degree of *coorientaing* so that his/her responses are genuine, although the nurse's sense of privacy or personal self is not invaded. To illustrate, there are times in a nurse's work life, that she/he needs to maintain some distance from the client in order to protect him/her self. This does not mean that the nurse is unwilling to enter into a situation in which pathic concerns predominate, or that the nurse will be unable to respond. Nurses can and do respond sincerely and caringly, simultaneously distancing themselves from the emotional demands in the encounter. It is a way of surviving in an profession that can be extremely emotionally traumatic. The salient point is that the nurse is willing to work with the client to create a place in which it is possible to focus on these types of issues.

Coorientation is a temporary alliance between aspects of the persons of client and nurse. The client needs to feel that the nurse is engaged with him/her as a person and that this engagement is mutually meaningful. To synthesize the meanings of both Kellerman (1986) and Ingram (1991), the interaction is meaningful in an essentially human or *pathic* way, because it is meaningful to the client, as he/she can express an essential aspect of self, and it is meaningful for the nurse because even if the nurse does not entirely fulfill the client's expectations, the nurse is involved, responsive, and unrestrained by role rituals.

The skills or approaches that allow for coorienting are within all nurses - they are the human responses to grief, tragedy, anger, pain, and loss. Choosing not to be available to co-orient is not necessarily a negative feature, if that is the agreement explicitly or implicitly chosen with the client. These choices are negotiated through touch, body language, and politeness. They determine the level of interaction; a role guided gnostic interaction in which the personal self is kept private, a less ritualized interaction in which pathic concerns are addressed although the nurse at least distances the private self. This type of interaction may be characterized by a sense of privacy.

If a client makes it obvious to a nurse that the pathic needs are the client's immediate concern, the nurse can indicate his/her unwillingness to respond, simply by reacting with politeness, in a manner that indicates his/her desire to maintain social distance. For example, noncommittal, avoidance, or hedging type responses may be used to discourage discussion on a particular topic. Small talk can be used as a diversion strategy, or

diminutive statements may be used to trivialize the problem. Expressions of disapproval, or resentment about the client's lack of effort, motivation, or aspiration may also be a means to prevent the client from feeling safe to return to the pathic concern. Consider the following example; a third day post partum mother, who has just burst into tears may hear a nurse reply; "do not worry - this is normal baby blues, it doesn't mean anything", or "its quite normal, you will get over it", or even "it just means you need some sleep. Then you will feel better".

In this model, the choice to coorient or not results in four levels of interaction; gnostic superficial and ritualized transaction; interaction that is pathic in nature but still bound by roles by at least one of the participants so an environment of privacy is created; forced anonymity, in which role based gnostic contact is forced in order to cope with the embarrassment of a coexisting prior relationship (such as a personal friendship) that is incongruent with the present nursing situation; and lastly, an encounter in which the need and response is pathic to the extent that the relating to each other transcends roles in terms of sense of closeness and intimacy.

Privacy and intimacy

When the central theme of politeness was identified, and the researcher's mind set was oriented toward a multidimensional structure of *anonymous intimacy* type situations, the variations of privacy and intimacy became meaningful. Each type of nursing interaction could be characterized by a particular type of closeness and connectedness between the nurse and client. Privacy and intimacy are conceptualized as coexisting states of being that refer to a person's ability to define his/her identity (or one's idea of how one wants to be in the eyes of another) in social interaction. Intimacy and privacy are not mutually exclusive - the act of revealing one part of *self* involves concealing another part of *self*.

Privacy refers to keeping some aspect of *self* private or concealed from public view. This occurs as control over one's presentation is exercised through controlling the boundaries between *self* and other. Simpson and Weiner (1989) express this well: privacy is something that belongs to the individual that helps the person maintain some sense of freedom from interference or intrusion. Privacy is the impression that there is still a secret retreat within a public situation. Privacy is closing the *self* off from others, if not in a physical sense, then in a social, interactional, psychological, or informational sense. Privacy enabies individuals to bolster and restore self-esteem by interaction, and to minimize emotional stress by withdrawing. It is a way to control the transaction and to minimize vulnerability (Laufer, 1977; Bercheid, 1977; Kelman, 1977). Thus, although there is intimate action, it refers to the (legitimate) encroachment into private areas

necessary for nursing care to occur, but which may be distanced from the private self. Maintaining one's privacy is, simply, putting one's best foot forward by concealing faults and restricting what is divulged to others (Burgoon, Parrott, Le Poire, Kelley, Walther, & Perry, 1989).

Privacy therefore, refers to the ability to control one's social identity by controlling information relating to claims for a particular identity within a specific interaction. Privacy is pertinent to situations in which an individual wishes to maintain a particular type of relationship. Privacy refers to the type of interaction, that is often regarded as essentially impersonal in that the level of involvement does not actually reflect anything about the social relationship between the individuals, only the service or task relationship (Patterson, 1982). The involvement is more gnostic than pathic for one of the participants. To illustrate further, an observation by Foddy & Finighan (1980) is most illuminating:

> What can an individual do to achieve and maintain a chosen identity? Probably the main thing he can do is to use devices to avoid letting the other see him either doing or not doing the things that conflict with the definition of the identity he wants the other to accept. But he will also be concerned that the other does not gain information in less direct fashions. (p.6)

It is proposed that nursing clients use a variety of devices to achieve privacy in nursing encounters, including physical compliance with verbal and non-verbal behaviors that indicate a desire to be left alone. In a slightly different way, nurses may also be able to help clients with pathic concerns in a sincere way without involving the essential parts of their private *self*. Politeness is a vital way in which this message may be related without causing offense.

Self disclosure, or the verbal or non verbal revealing of information, is the main way of negotiating privacy in social interaction (Derlega & Chaikin, 1977; Balswick & Balkwell, 1977; Zerubavel, 1982; Fisher, 1984; Miall, 1989). Self disclosures may be permitted in certain restricted areas of the clients life in order to fulfill the goals of receiving assistance. Beyond this though, self disclosures are tightly controlled, depending on the clients desire for privacy, or the nurses' willingness to accept this type of self disclosure. It is recognized in nursing research, that patient self-disclosure beyond that perceived as relevant to their problem is not spontaneously produced (Young, 1988), even though there exists an assumption that nurses should delve into most aspects of the client's life. This is not accepted in this model as part of everyday encounters with clients. It may certainly occur if there is indication that it would be productive in terms of nursing care but this is the exception rather than the norm. Breadth of disclosure may replace depth of personal disclosure as a mechanism to regulate contact (Derlega & Chaikin, 1977) and even just to

maintain contact. It is this polite social contact that is often the precursor to a different level of interaction. Alternatively, discussion of a purely social nature - the weather, news, sometimes information that is accepted as public (such as the number of, and activities of children) - is legitimately used as an avoidance tactic that firmly, but politely, indicates a reluctance to move the interaction to a different level.

Intimacy is the sense of sharing of *self* as an essential human being. It may not be exposure of all aspects of the self but it is meaningful contact with another *self*. It generally occurs in relation to a pathic concern. The aspects of self disclosure still apply to intimacy in that people have many aspects to the *self*, and sharing of one aspect may mean not sharing another. The difference is that what is shared may be deeply pathic and which requires a pathic response. Intimacy is mutual perception and knowledge of special closeness with another human being.

The idea of intimate behavior must be distinguished from either privacy or intimacy. Intimate behavior does not necessarily imply a sense of intimacy. Intimate actions - such as physical examinations, or health histories - may focus on the very personal aspects of a client, but be carried out in contact that is gnostic in nature. In this way, intimate behavior can occur within an atmosphere of private impersonality, or of interpersonal sharing.

Summary

The main concepts in the model of the *Dance in Caring* has been presented. The central theme in this model is politeness, or the verbal strategies nurses and clients use to negotiate social distance, formality, and informality so that the private *self* may be protected through use of role based interaction, whilst still effectively cooperating in attending to the client's gnostic and pathic needs. The major premise in this model is that the social sanction of nursing provides a passport for a nurse to enter into the private spheres of a client's life. Clients' acceptance of nursing care involves an implicit acceptance of the impositions that this care may involve. Effective and appropriate nursing care is offered by the decision of the nurse to recognize the distress that the client may experience. Nursing care is offered in a manner that is sensitive to the self esteem, self competence, and autonomy needs of the client. In the following chapter, the four types of nurse-client interaction are described. These types of interactions are characterized by the nurse and client's decisions to coorient to gnostic or pathic concerns, and the degree with which the private *self* is protected through use of role guided communication and behavior. These decisions result in a specific kind of privacy-intimacy.

VI. FOUR TYPES OF NURSE - CLIENT INTERACTION

The various ways of relating between a nurse and client give rise to four natures of interaction (Figure I). They reflect the relative balance of pathic and gnostic contact between nurse and client. The *Dance in Caring* model is limited to nursing contacts considered to be caring, which result from mutually negotiating and agreeing on the nature of the interaction. If it is not, then the interaction would be characterized as uncaring, and thus outside the bounds of this model. This chapter outlines the four main types of interaction in the model: Gnostic contact (predominance of service-instrumental goals); Sanctioned privacy (gnostic contact mediated with pathic responses); and Privileged intimacy (true pathic contact). The theoretical explanations are then followed by imaginary clinical examples to ascertain the adequacy of the theoretical description.

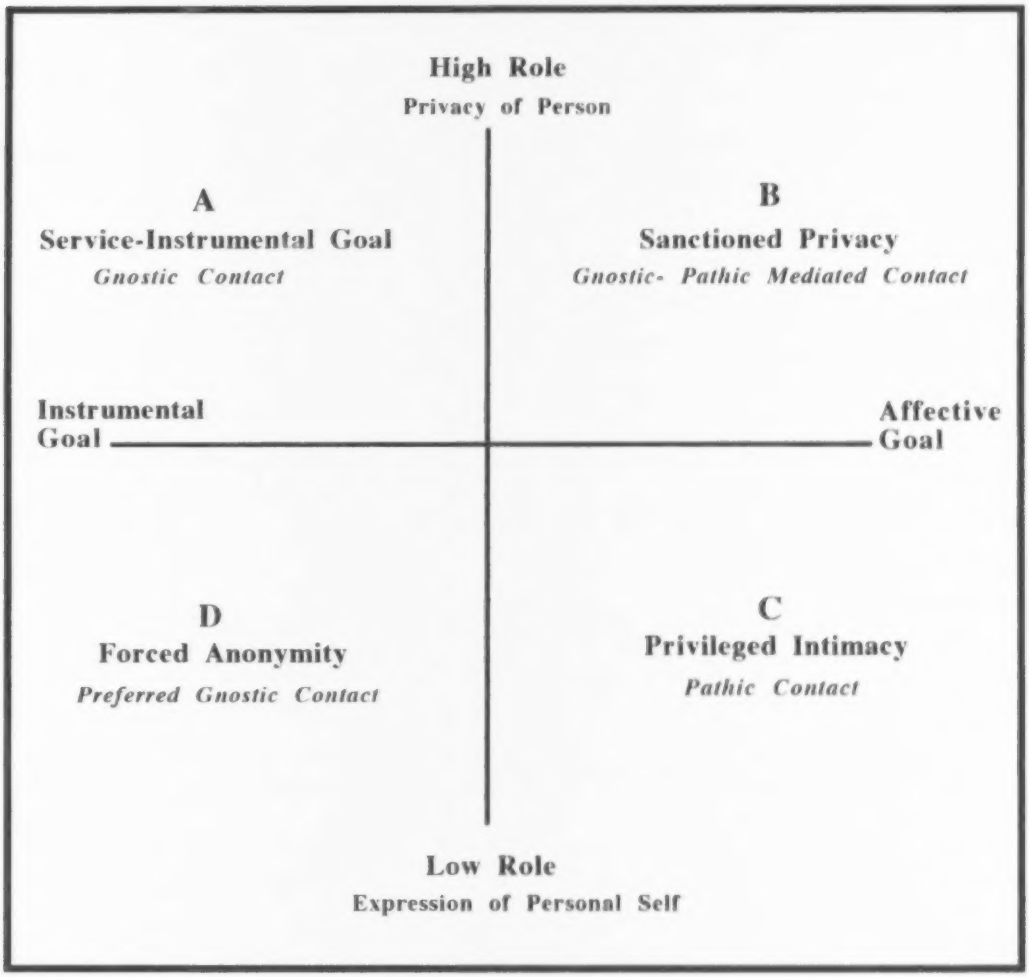
Gnostic contact: Predominance of service - instrumental goals

The physical presence of a nurse at a client's bedside does not ensure that meaningful information will pass between them. Contrary to Kadner's (1994) claim, the conditions promoting intimacy, seeing the nurse more frequently or having access to vulnerable areas of client's situation, do not result in intimacy if the nurse and client choose not to perceive the other beyond the roles assumed in order to address the instrumental goals of nursing care. Private information may indeed be offered by the nurse, but it may be both offered and received in a manner that effectively separates it from client through objectification. This objectification is not necessarily a negative phenomenon, as long as it is congruent with the client's preferred need for assistance.

The type of interactions that occur here are often regarded as impersonal. They are often highly ritualized, so that each participant does not behave beyond that expected within the role. The main concern is the instrumental goal. Personal problems, that are the focus of nursing assistance, are regarded in a gnostic manner. In some ways, the interaction may seem to entirely objectify the client; that is, the client is regarded only in terms of instrumental activity. There may be conversation, but it is social in nature, except for the discussion directly pertaining to the instrumental goal. Each person's private self is largely hidden, it is the role that is used to relate to the other. A somewhat negative attitude to this type of encounter, but one that nonetheless contains an element of truth is Waterworth and Luker's (1990) concept of "toeing the line". This describes how nursing clients attempt to do the right thing, by discovering the rules and exhibiting the right behavior expected in these interactions.

FIGURE I

OVERVIEW OF THE TYPES OF NURSING INTERACTIONS IN THE MODEL OF THE *DANCE IN CARING*



In this type of encounter, privacy means the concealment of the self, and the projection and dominance of a role based aspect of identity- the "client" and the "nurse".The interaction is guided and constrained by the typical sequences expected in impersonal interactions. In other words, although intimate actions may be performed, the exchange has less interpersonal relevance for the interactants. Managed low involvement is a way of making the exchange more comfortable for the actor (Patterson, 1982). Politeness is essential (among other behaviors) to soften any perceptions of excessive distancing or impersonalisation.

Either the nurse or client may block an attempt by the other to move the interaction to a different type of contact. These attempts may occur either as spontaneous client disclosure, or nurse probing. Blocking is the decision or desire of one person to avoid personal involvement in the situation. However, using the politeness model, it is likely that there will be a perceived need to support the other's face by avoiding embarrassment by an outright indication of disinterest. So, as Vanlearr (1987) found, the importance of tact -avoidance or indirectness, discretion, and restraint is highlighted as the motivation for a noncommittal and nondisclosive response to the other's disclosure.

In this type of situation, it is the role that is the main vehicle for interaction, and thus for recollection of the other. It is the role of nursing that is recognized and remembered as important, rather than the individuals who are offering the nursing. This is not a comfortable concept, but it is a normal feature of the way we act in daily activities. For example, it is worth considering whether we generally remember the names and individual identities of supermarket cashiers (who do tend to wear large name badges), or the bank tellers we may meet on a regular basis. These interactions are usually entirely instrumental-goal oriented. They are gnostic contacts, based on the service, skill, and knowledge we wish to utilize. We are interested in the service, not the server. Gnostic contact, or interaction that is on a cognitive, objective, and an impersonal level is sufficient to obtain the required assistance or service, and to keep the *self* private.

The way this is done in social interaction is by manipulating social distance. This is not hard to do in social interactions that are already fairly well defined in terms of expected service, power imbalance, and ritualistic behavior, such as medical and nursing situations. One of the most effective communication tools is politeness, to increase and decrease social distance by facilitating and discouraging familiarity and formality, by providing a way to cover self's embarrassment and threats, and to also disguise threats to the other. Impersonal terms of address, either title ("nurse") or impersonal pronouns, or even avoidance of using any form of address is another way of creating social distance and

increasing the level of formality. Politeness is only one tool, but it is one that is so taken for granted in social life, that its effect in nursing interactions has gone virtually unnoticed.

Sanctioned privacy: Gnostic contact mediated by pathic responses

If a client's self disclosure, or a nurse's probing is not blocked, then this may be perceived as a willingness to move to another type of communication. In nursing situations, client self disclosure may be acknowledged by expressions of tact, approbation, and solidarity, that support the client and signify that the nurse is open to increasing the sense of closeness and intimacy in order to tend to pathic concerns. Thus interaction may still be bound by roles, but some aspects of the private *self* is used as the focus and instrument of care.

This milieu of privileged privacy allows clients to participate in the nursing encounter in a variety of ways - as an objective and analytic observer of the experience or body part - in order to provide the nurse with information related to the instrumental procedure, and as the subjective person able to experience, express, and manage the experience. Privileged privacy refers to the phenomenon that clients may be required to present their body for examination, but this may not mean that they actively participate in the business at hand (Heath, 1989). It is possible for patients to adopt a "middle" distance orientation, by distancing themselves from the activities being performed. In this way, "patients are able to manage a range of painful and potentially embarrassing actions and events " (p. 114). However, when there is need for more active participation - either as a speaker or informant, or as an object of inspection, there is a rapid change in alignment, so that the type of participation alters to meet the changing needs. Thus, movement between levels of participation is constantly fluid, reflecting the type of information or expression required by the nurse.

However, whatever the activeness of participation, the role of client - whether as objective observer, or subjective experience, predominates. The self image projected is more or less tightly controlled so as to present a congruent presentation of a suffering but managing and cooperative client. Self exposure is required and given in the appropriate areas. This form of simultaneous intimacy and privacy is unique to health care encounters. The nursing responsibilities in caring for human beings thus goes beyond the instrumental care or treatment to facilitate the client's pathic experiences.

Privileged privacy then refers to the private togetherness that describes the cooperation in achieving gnostic with associated pathic concerns in nursing encounters. It is based on role guided interaction that still facilitates client participation by the client in a variety of ways. Knowledge or interest in the other beyond the areas associated with the instrumental

goal is limited. The overriding need is the instrumental goal, but the way it must be addressed requires a more pathic response. A good example of this type of interaction is the verbal play observed by Ragan (1990) in the interaction between nurses and clients having a gynecological examination. Taylor (1992) too, reports that;

> " The patients attune themselves with the nurses because of their sense of affinity with the nurses as humans. At the same time the patients acknowledged the nurses' knowledge and skills and allowed themselves to be supported by the nurses' professional qualities and activities. The shared sense of ordinariness between nurses and patients made them as one in their humanness and created a special place in which the relative strangeness of the experience of being in a health care setting could be made familiar and manageable."(p.35).

The nurse, in the process of coorientating to the client's pathic needs, attends to the client as another human being. Shurpin (1989) observed that this attending involved not only humor and anecdotes, but conversations that not only seemed polite but very ordinary, even when they were focused on a sensitive area. This is the one of the unique skills of nursing.

The social distance between nurse and client can be based on distance in relation to role does not have to be close in terms of the nurse's personal closeness. The nurse can respond in a sincere and appropriate manner without involving her personal self. This, emotional distancing, is one of the survival mechanisms nurses use to cope with the multitude of situations faced in nursing practice. The nursing response is congruent in terms of expressions of concern, empathy, attentiveness, and comforting, but these responses are drawn largely from the repertoire of the nursing skills. In other words, just as the client is able to manipulate his/her participation through objectification or distancing the *self* from the activity, the nurse also is able to distance the *self* from the nursing responses. The interaction is "middle distance" in terms of role and private person balance. It is an individualized role guided encounter.

Terms of address may be more personal during the encounter but beyond the encounter the specific identity of the nurse is not important. In other words, the nature of the need requires a personalized approach which may be offered even though the nurse restricts personal involvement to that which is absolutely necessary. These encounters are personal and sincere but still have limited personal relevance for the nurse.

This is the nature of most routine nursing interactions. This is the type of interaction identified by Christensen (1990) as the paradox of *anonymous intimacy*. It is not a paradox as the nurse and clients are not strangers; they are familiar to each other on the basis of roles. Nor is the interaction intimate. It is personal and private, but the interaction is still

guarded and reserved. This type of interaction does indeed refer to a relationship based on relating to the role of nursing which is individualized for each particular encounter. It is not, however, a contextual feature influencing all nursing interactions; it is a particular type of relationship and a specific way of relating to another person.

Privileged intimacy: Pathic contact

Privileged intimacy is the sharing of the self that goes beyond the gnostic-pathically mediated contact. Intimacy refers to the way nurse and client meaningfully relate to each other as one self to another. It is still defined by the role boundaries, especially in terms of obligation incurred (little as this care is within the domain of nursing), and expectations of a future relationship (there may not be a future). Involvement in this type of encounter is less managed and more spontaneous. The purpose or goal of the interaction may still be part of the nursing goal (for example, emotional, spiritual assistance), but the nurse's response must draw on more personal resources than generic nursing ones ordinarily used in routine encounters. The essence of these encounters is the coorienting to the absolute importance of the pathic nature of the nursing need and care.

Interactions that are characteristic of privileged intimacy rely on a genuine connection between personal selves. It is a very special type of relationship, created, experienced, and usually ended within the space of the encounter. It is a situation in which the nurse is able to help the other person by offering his/her *self*. It is similar to Benner and Wrubel's (1989) concept of "presencing". Roles are discarded and politeness is not used to create or maintain formality or social distance.

There is no guarantee that the same level of interaction and contact will be sustained beyond the encounter. It is probable that the nurse and client would have a more personal general relationship unless the client or nurse indicates that this would be perceived as inappropriate. This experience is very special, something that is likely to be remembered, so it is also likely that the personal identities of the nurse and client are afterwards remembered and perceived as more important. Perhaps during the encounter forms of address in fact do not matter. The significant part of the care is the affective connection not the language.

Forced anonymity: Preferred gnostic contact

The fourth type of nurse-client contact was not originally conceived as part of the model of the *Dance in Caring*. However, it became clear that contacts in which both participants desired forced formality or gnostic communication even though in other situations, interaction would be friendly and informal, would also be characterized by high levels of politeness. Forced anonymity was conceptualized as those nurse-client contacts

which were deliberately set on a formal basis as a way of coping with the embarrassment resulting from a previous relationship that is incongruent with the current contact. The most typical example would be two close friends who find themselves in a nurse-client situation, and in which the nature of the contact is of a nature that feels very uncomfortable in relation to their usual way of relating as friends. This type of contact is not likely to be common, but it is a situation in which correct use of politeness is critical to mange negative feelings, and so to protect the prior relationship.

In this kind of situation, both nurse and client may experience embarrassment as the communication or actions revolve around areas that were not part of the friendship. For example, two women who are friends may share their experiences regarding sexuality, and health in sexuality but then asking those friends to carry out gynecological examinations or investigations goes beyond the bounds of the friendship. If this should occur, then interacting on the basis of modified roles becomes important as a means to distinguish between the friendship and the nursing relationship. The roles of client and nurse act as controls and boundary markers in the contact. Tact, avoidance, indirectness, and restraint become important in mediating between recognizing the situation as awkward, and trying not to appear impersonal or embarrassed.

The health care concern can be objectified in much the same manner as in the gnostic type contact. This allows the client *who is friend* to be separated from the concern that is the focus of the nursing interaction. Objectifying the concern allows for easier distancing, or increasing of social distance and increasing formality in a subtle and tactful way. The milieu may be perceived as private but somewhat awkwardly personal/impersonal.

The type of contact in Forced Anonymity is not the opposite equivalent of either Gnostic or Sanctioned Privacy interactions. The mixture of gnostic, pathic, and friendship / social contact is likely to highly complex, as the nurse and client continually negotiate a comfortable type of communication through manipulating self image as *friend* or *nurse/client*. Terms of address will be personal and specific rather than impersonal, indirect, or avoidance based. Verbal play would be very much in evidence as one way to simultaneously reaffirm the friendship and place it aside for the duration of the nursing contact.

Summary

The four main types of nurse-client interaction have been described. These interactions are described as typical, or stereotypical images of the contact that nurse and client negotiate. These four types of interactions do not represent the vast range of interactions

that fall within and between each extreme quadrant. In the following section, four case scenarios are present to illustrate each of the types of nursing interactions.

Case Scenarios

Scenario I. Service- instrumental goal type interaction

Mr. Jones is about to be catheterized by Donna, the nurse who has been assigned to care for him. He is anxious about this procedure, as it is highly embarrassing, concerning a normally private part and function of his body. He wants to get it over and done with as quickly and painlessly as possible. "The sooner all this is over", he thinks, "the sooner I can get back to normal life". Donna enters the room, pleasant, and cheerful. After some time, however, it is noticeable that the conversation is - pleasant. Talk about the weather and news is interspersed with Donna's requests for Mr. Jones to shift position and her inquiries about discomfort or warnings of possible discomfort. Soon the conversation seems almost stilted. Eventually there is mostly silence. Donna finishes up, and announces, "here, that's it. You were great". Mr. Jones smiles and says, "thanks - you nurses make all this really easy."

Scenario Analysis

In this scenario, Mr. Jones wants to preserve as much privacy as possible in this interaction. He perceives the catheterization as threatening to his self image, his self esteem, and sense of competency. He has anxieties concerning his dignity, lack of composure, and having a stranger perform this very intimate task. He is embarrassed. He knows that nurses are skilled at helping people through this kind of experience. He assumes that the nurses would not be embarrassed as they must do this kind of thing all the time. He has never been nursed in this kind of situation before, but from his experiences with his physician, with the nurse working with the physician, as well as his general knowledge of what nurses are, he is very aware, that if he helps the nurse as much as possible in the procedure but distracts her away from personal conversation, this might be over and done with quickly. He chooses to preserve his privacy by interacting in a polite, but largely impersonal manner.

The catheterisation occurs almost as if it was being done on someone attached to him, but not belonging to him. This is not to say that he does not experience the discomfort, but he manages to hide this, except with the occasional comment to let the Donna know how he is doing. This helps tell her that she needs to change her technique slightly. Otherwise, their communication and interaction is fairly routine. He does not want to disclose any other part of himself if possible. He is not interested in becoming involved in a conversation about his family or health habits. His only goal is to get this procedure over

and done with. His verbal and non verbal manner indicate to Donna that this is the case. She acknowledges his desire and responds using the appropriate polite and ritualistic forms and topics of conversation. Thus Mr. Jones perceives the communication as non threatening, suitably distracting, and comfortably impersonal. There is an apparent avoidance on the part of Mr. Jones to address Donna by any term at all. Donna addresses Mr. Jones as "Mr. Jones" which is comfortable as throughout his hospitalization, he has not invited anyone to change it to "Bob". The last comments indicate that each appreciated the efforts of the other. It is mutual thanking. Note though, that the comment Mr. Jones makes is general - applicable to all nurses rather than just Donna.

In this scenario, politeness is being used to maintain as much social distance and formality as possible to protect Mr. Jones' privacy. The interaction is based on gnostic contact; role guided, largely routinized or ritualistic communication. It is reserved, polite, but ultimately impersonal. Each person is being recognized by role function - the patient-object, and the nurse-technician. Mr. Jones may remember Donna as the nurse with the long hair, and Donna may associate Bob's name with the reason for admission, each is likely to forget this soon after contact finally ends. The persons of these roles are not primary. Politeness is used to ease direct threatening requests and avoidance is used to avoid undesired depth or breadth of disclosure by Mr. Jones or unwanted probing by Donna. The last exchange is toward the others positive face however, social distance is again emphasized by the generality of Mr. Jones' remark.

Scenario II. Sanctioned privacy: Gnostic -pathic mediated contact

Sue is awaiting the results of her abdominal biopsies. Her wound is healing slowly, and she is becoming more and more anxious about the possibilities and implications for her future. She resolves that when Mary, her nurse, comes to dress the wound, she will reveal all of her fears about the impact this problem will have on her life. Mary, however, has had a harrowing day. She is looking forward to the end of the shift. She thinks doing Sue's dressing should be fast and simple; after all, Sue is getting along very well. The encounter starts with the general comments and requests revolving around preparing the site for dressing.

Every time Sue tries to bring the subject of her worries up, Mary seems to head it off in one way or another. Using comments such as "I really think you are doing well, don't you?", or "all patients have these fears - it is quite normal", or "you must be looking forward to your Doctors' visit tomorrow" or "yes, you need to talk to your husband about this" or "do you want to see a priest or chaplain?". Sue was becoming more and more distressed. She hid it well though. She responded whenever that seemed to be required, but

avoided any attempts on Mary's part to involve her in distracting conversation - replying with "hmmms", or "yes".

However, just as Mary was cleaning up, it became too much. Sue started to cry. Mary stopped cleaning up, sat on the bed, and put her arm around Sue. Mary said "do you want to talk about it?" Throughout the next while, Mary was caring and concerned. She listened and responded, sharing her knowledge about this kind of situation. Eventually, Sue felt as though she had got it out in the open. She felt relieved. She remarked "I suppose you nurses get a lot of this". Mary laughed and said "Well, this is what nursing is about".

Sue and Mary ended the interaction with Mary saying that if Sue needed to talk, further, Wendy would be her nurse for the evening, or that there are nurses about constantly.

Scenario analysis

Investigating Mary's feelings once she had accepted that Sue needed to express her concerns, we find that her response to Sue's distress *was* caring and concerned - but as a nurse, Mary has experienced similar situations. Today, she just could not handle anymore emotional pressure. She wanted to comfort Sue, but she could not allow herself to be personally or emotionally involved.

In this scenario, initially Mary attempts to avoid entering a pathic type of contact through the politeness strategies of avoidance, and diminutive suggestions and support. Eventually, Mary recognizes that Sue's nursing need is of a pathic nature. To ignore this would be to fail to offer nursing care to Sue. Thus, at the end of the interaction focusing on the gnostic concern - the wound dressing - the primary goal becomes Sue's pathic needs. Sue needs to share aspects of her private *persona* to deal with the trauma associated with her medical problem. Mary wants to offer care and comfort, but does not have the resources she needs to sustain a period of intense offering of herself. Her response is contained within her nursing role guides. Politeness is used to attend to Sue's pathic needs but also to maintain a sense of distance. Help is offered through the role of nursing.

This is an intensely private and personal situation for Sue. She reveals things that she has not had the courage or opportunity to discuss with anyone else. It truly is a very privileged revelation of the private aspects of Sue's *self*. Her disclosure, and Mary's response is perceived as caring and appropriate, and is possible because of the passport nursing provides to establish the trust Sue has in Mary's ability to comfort and care. If Mary had not been on duty, Sue may well have chosen to do the same with the next nurse - or, when the stress became unbearable- to any nurse she met.

Politeness is used by Mary to respond affirmatively to Sue's feelings, but also to allow Mary her own privacy, by drawing on the nursing aspect of herself, reducing her emotional

involvement. The outcome may be that for a while, Mary's name or individual identity will remain clear in Sue's mind. Soon it will fade. Certainly Sue will recognize Mary by sight - after all, it was a very personal encounter but Sue fundamentally appealed and was responded to, by nursing. Mary's way of sincerely responding involved maintaining distance. This is evidenced by few interpersonal indications of solidarity; solidarity was with other patients; and the support and perceptions Mary offered were drawn from Mary's experience (real or learned) of nursing.

Scenario III. Privileged intimacy: Pathic contact

Mabel is a long term, terminal laryngectomy patient. After her radical laryngectomy, she had undergone radiotherapy, experiencing the burns and complications associated with this. She had metastases of the tongue. She begged to go home, but when she was finally discharged and returned to outpatient clinics to be weighed, she slipped, fell, and severely broke her arm and shoulder. She was a favored patient on this unit. Mabel was helpful, friendly, communicative, and cooperative when things were not going right - such as changing her analgesia. She would provide treats for the nurses, but treated them all the same. Despite all of her friendliness, she was a reserved and gentle person. One evening, Brian, RN was working with short staffing - his colleagues were two LPNs and a student. Luckily the unit was not too busy.

Betty, a LPN looking after Mabel, came to Brian to check out Mabel's narcotics. Half an hour after these had been administered to Mabel, Brian asked Betty whether her pain was under control. Betty said that she seemed fine. This did not seem to satisfy Brian. Something was wrong. Eventually, he went down to check on her personally. He found Mabel in extreme distress. She was shouting and screaming and wailing in a heart wrenching manner that those with laryngectomies can sub vocalize. It took a while - almost half an hour - to find out what was wrong. In the meantime, it took every ounce of attending and response in Brian to comfort Mabel. It did not seem to do any good. She was sweating and rocking, crying in agony and distress. Eventually, Brian just sat cuddling her, talking in an almost sing song manner which was unintelligible. He made little effort to discover any information, but slowly, bit by bit, the cause was identified.

The arm harness holding Mabel's arm had become disrupted, causing her extreme pain. Looking at it - a little at a time - as Mabel was insistent that he concentrate on her unintelligible mouth movements, he noticed that the arm was badly swollen and turning reddish black. This was no simple readjustment. Brian rang the call bell, and asked Betty to page the doctor. The reply from the doctor was that she would be along "in time". Brian decided that Mabel's response was indicative of something more serious, and managed to

excuse himself to call the doctor to urge immediate attendance. Eventually the doctor came, administered a stat dose of morphine, and ordered blood tests and x-rays.

All this time, Brian was involved with Mabel. In some ways he became part of her; her voice in explaining and describing and persuading the doctor. He was another being in responding to someone in agony. Eventually the narcotic was effective, and the tests showed a substantial hemorrhage and displaced fracture. Brian ended the shift exhausted but immensely satisfied. He had helped another human in a time of great need, not through his nursing knowledge, but essentially by being himself. A few days later, she grabbed him by the arm, and with tears, expressed how much he helped her that day, and how much she thanked him for it. To tell the truth, he was a little embarrassed. After all this was his job. It was true that he had the choice of how he responded. This time he chose to put her above any other priority, to commit himself to her for that particular need.

Scenario Analysis

The types of interaction described here are the type that make a nurse's momentous occasion - or paradigm case - memory. It is, to use Benner and Wrubel (1989) words:

> *being with the patient in such a way that acknowledges your shared humanity* ....It includes being 'in tune' with each other, an awareness of unique personhood (Simons 1987, p. 2, cited in Benner & Wrubel, 1989, p. 13).

Benner and Wrubel claim that this type of nursing encounter is the basis of much of nursing practice. It may be the basis of nursing - the motivation and goal of nursing - but it is not characteristic of the vast majority of every-day nursing interactions. Nurses may indeed have the tendency to be open to the possibility of this type of client contact, but it would be exhausting to do this in every interaction of the day. This type of nursing care is the pinnacle of nursing, it is the use of *self* that is finely tuned and skilled through nursing experience, but it is fundamentally the person of the nurse rather than the role of the nurse that provides the comfort and care that Mabel needed. Brian's response was on a very genuine human level.

Politeness is not used to create a social distance or formality, although that is not to say that normal politeness conventions may not be apparent. The connection is between *selves*. Roles are discarded. The intimacy experienced is quite special - it is way beyond the bounds of everyday expectations. The focus is virtually entirely of a pathic nature, although Brian's secondary role is to carry out the physical activities of investigating the cause of the distress. Brian chose to be with Mabel as an extension of the supporting part of her. It is intensely personal for both Brian and Mabel. Brian learns as much from Mabel as the comfort he is able to offer her. It is likely that neither will forget the other. Future

interactions may be still friendly, but the intimacy they have experienced is not sustainable. There will be an unstated understanding of the ordeal they faced which will influence future interactions. It may be that such intimacy will not be desirable in the future; either Bill or Mabel may act to create a higher level of formality in future encounters but for a long time, both Brian and Mabel will remember each other as "special".

Scenario IV. Forced anonymity: Preferred gnostic contact

Fran and Claire have been friends for a long time. They live near to each other and visit or talk frequently. Their friendship is based on their shared years of school, marriage, and starting families. Now, Fran has been admitted to hospital with appendicitis. She is on the unit on which Claire works. For a time, Claire manages to avoid being assigned to nurse Fran, as she senses it might be a little awkward. It does not stop Claire from visiting frequently, or following her progress. One day, Claire is assigned to Fran. She enters to assess Frans condition. The situation is a little awkward. Their relationship has not involved interactions of this nature. There is a lot of joking, shared stories, and also objectification of the nursing activity going on. Focus on the instrumental concerns tends to be announced clearly, and this indicates a change in the form of interaction - Fran becomes almost as if she too was looking down on what is happening. In these episodes, it is noticeable that both address each other indirectly through the wound - "it's looking better...", "wonder how long it will be until the stitches come out". Their friendship is there, but it is placed on the side, it does not fit this situation. Although neither seem to actually assume any role related communication or behavioral strategies, the interaction is still formal and distant. It is private, and Claire's attitude is of professional concern. The interaction ends with very cordial expressions, but an almost invisible sense of relief.

Scenario Analysis

This type of encounter is a variation, but opposite of *Sanctioned Privacy*. This type of interaction occurs between people who are personal friends, but who are placed in a situation of invasion of privacy as part of a health care need and nursing response. In this type of situation, although the two are friends, their knowledge of the other is based on personal social knowledge. The nursing situation has placed them in a difficult position; the activities to be carried out are not part of the way they know or relate to each other. Certainly, they may have discussed these types of activities, but in association with someone else. The nurse-client relationship involves relating to each in a different way.

To cope with the changing relationship, there is a deliberate effort to initially acknowledge and confirm the existence of their friendship, but then to place it aside as incongruent with the demands of the present situations. The interaction is kept from this

point on as gnostic contact. The activity is cognitively rather than affectively perceived. In this type of situation, it is possible that objectifying Fran's wound differentiates between the part of the Fran who is personal friend, and that which is client and nursing object. Politeness may be used to create social distance and to cope with the embarrassment each may feel. Politeness helps maintain poise and composure through objectification of the health concern. There is a high degree of sanctioned privacy, but the roles and private person are balanced more finely.

Summary

The central research question guiding this study was "*what is the concept of anonymous intimacy?*" The process of critical reflection on the nature of the concept of *anonymous intimacy* has resulted in a beginning model of the ways in which nurses and clients interact in caring nursing encounters. As social actors, people have choices about how they present themselves in social interaction. Assuming public roles eases social transactions by basing the encounter on generally understood behaviors and expectations. Roles also function to control expression of the private *self*. The function of nursing is to assist people experiencing health related events. Nurses are able to do this through virtue of the social sanction of nursing, the passport to immediate access to the client. Interactions such as those observed by Christensen (1990), in which there is simultaneous intimacy and anonymity, and where the client appears to identify with nursing rather than individual nurses, are one type of nursing interactions that have politeness as a central feature of communication. The model of the *Dance in Caring* is a beginning model describing how politeness is used in nursing encounters to control, guide, and mutually negotiate how nurse and client will relate to each other.

VII. DISCUSSION AND CONCLUSIONS

The model, *Dance in Caring*, has been presented as the latest stage of development that started with concept clarification of *anonymous intimacy*, described by Christensen (1990). A politeness framework is the central theme of the model which describes how nurses and clients negotiate a comfortable type of interaction. Politeness is one verbal communication strategy used in social interaction. In this study, the manner in which verbal expression is used to create an interaction context is examined. This does not imply that respect and courtesy are not offered and perceived through other forms of non-verbal communication. The nurse and client negotiate interaction based on role guided ritual, personal connectedness that is still restrained by role boundaries, true connectedness between the *self* of the nurse *persona* to that of the client *persona*, and forced formality and role assumption when a previous relationship is inconsistent with the present situation.

The discussion section of this thesis is offered as a bridge between the work that has culminated in the model of *Dance in Caring*, and some preliminary ideas about how the work (in particular strengthening of the assumption of display of respect through courtesy in non-verbal as well as verbal communication), should be pursued in the future. The researcher's mental picture of the process undertaken in this work is of an ever growing helix, a pattern that is circular in evolution, but never actually returning to the beginning. This theoretical concept development has been a continuous cycle of development, reflection, critical analysis, and further development. The cycle does not stop with the conclusion of this study. In this chapter, the researcher offers some reflections about the process of concept synthesis undertaken as the research method, and a discussion of the similarities between the *Dance in Caring* with the origins of the concept in Christensen's (1990) work. One issue that is central to this model, the idea of the use of *self* as role rather than the use of personal *self* in nursing, is briefly addressed.

Concept synthesis

Development of the model of the *Dance in Caring* has been very much a qualitative process. Codes have been generated, expanded and combined, and a central theme, based on politeness, identified between categories. It has been a helix cycle of development, synthesizing new meanings or relationships, then returning and critiquing the work to identify areas needing further analysis.

When the work began, long before the formal start of this thesis, the researcher's intention was to define the concept of *anonymous intimacy* through concept analysis, using one of the traditionally accepted forms of concept analysis in nursing. This process was difficult and unsatisfactory. After a period of reflection, the researcher believed one

problem with the process lay in the fact that it was concept development rather than concept clarification or definition that was required. The second problem was that the established forms of concept analysis seemed to be specifically appropriate for a concept that was ambiguous, rather than for a concept that was new and unique. As a consequence, this led to significant difficulties in using rather linear formats - such as those of Walker and Avant (1983) or Chinn and Jacob (1987), where one defines attributes, characteristics, and antecedents, then uses case examples to further refine those aspects. Attempting to define or describe something that had not been described before, especially something that seemed to be two or three concepts interrelated in some mysterious way, meant that this process generally ended in ambiguity. Nothing seemed to fit unless aspects of meanings were drawn from the original concept and distorted beyond acceptable bounds to fit the new concept. Even the idea of following a simultaneous concept analysis process as described by Haase, Britt, Coward, Leidy and Penn (1991) was ultimately discarded as inappropriate in clarifying a concept with multiple interrelating rather than parallel sub-concepts.

The conceptual leap that allowed this work to proceed in a profitable manner was the change from a "two dimensional" to a "three dimensional" way of thinking. The researcher began to approach the phenomenon of *anonymous intimacy* with the assumption that it was a model, a phenomenon that had many interrelationships of a three dimensional nature. The most successful ways of fostering this change in thinking once the main concepts and theme had been identified, was through creating play acting scenarios, and physically cutting and pasting ideas, sentences, quotes, or extracts from the annotated articles onto a plastic sheet nailed to the wall. This sheet was crossed by horizontal and vertical lines, resembling the "*Holodeck*", a space in which three dimensional and dynamic realities can be created in the science fiction program "*Star Trek: The Next Generation*". This rather simple device served as a constant reminder that no sub concept would have a "black or white, negative or positive" aspect, only multitudinous dimensions, a few of which were to be described in this research project.

Developing the model of the *Dance inCaring* has involved creativity and imagination. The researcher has attempted, in the main, to use the concept implicit in the model in the way that was originally intended by the original authors. However, in order to make some linkages - the extrapolation of politeness principles to nursing being the main one - some flexibility has been required. The audit trail of decision making provides the main way of tracing how these decisions were made. This model is largely theoretical conjecture, limited by the abilities and resources of the researcher, and thus remains as such until there is verification in clinical nursing practice.

The model, "Dance *in Caring*", was imagined to describe how nursing interactions develop. It is much broader in scope and replaces the original title of *anonymous intimacy* . It is reminiscent of the patterns of dancing, of two people moving gracefully and pleasingly as a couple on the dance floor. This ease of grace is not automatic. Each person must be sensitive to the other. There is a leader and follower, roles that may be constant between the two, or flexible according to desire. The follower's decision not to move in accordance with the leader's subtle instructions, indicated by physical pressure, results in a stumble, a transitory loss of coordination. The partners have to re-negotiate the dance steps. Re negotiating the dance steps, of course assumes that each persons is familiar with them before starting the dance. This is what happens in social interaction. Each person has an idea of the dance steps in social interaction, including how to approach another, how to initiate conversation with someone never met before, how to communicate one's needs, and how to encourage another not to pry too deeply into one's private spaces. The idea of dance is similar to Aronsson and Satterlund-Larson's (1987) notion of social choreography, which uses politeness to describe how people regulate social distance.

Politeness refers to specific verbal communication strategies used to manipulate the relative distance, intimacy, and formality in social interaction. In this study, the term "politeness" is used in the scientific sense rather than lay social connotations and understandings. It is anticipated that through further research, other communication strategies, such as touch, non-verbal language, and the music (pitch, inflections, and tones of the voice), will be identified as contributing equally to the way in which nurses and clients offer respectful courtesy in nursing interactions. Thus, the importance of the verbal strategy of politeness will be placed in context within the totality of social exchange.

Relationship to the Nursing Partnership

The evolution of *anonymous intimacy* into the model, *Dance in Caring*, has simultaneously supported and modified Christensen's (199) original concept and, more broadly, her model, *The Nursing Partnership*. Many of the concepts and assumptions are similar. The model of the *Dance in Caring* serves to extend and explicate aspects of Christensen's model.

Anonymous intimacy as a contextual determinant is not supported. It is not a variable affecting the nurse-client relationship within each nursing partnership, but is a specific type of relationship negotiated on the basis of a preferred type of interaction, privacy, and social distance. The variable determining the level of interaction is each participants desire to acknowledge gnostic or pathic concerns, and to use the private or public *self* to

communicate. The model provides a more specific explanation for the motivation and choice of nursing strategies described by Christensen in the nurse's work.

Christensen's conceptualization of the work that nurses and clients do in nursing partnerships is a critical aspect of how nursing is offered and received. She argues that nurses must continually do the work of *Maintaining Readiness* as part of preparing to enter Nursing Partnerships with new nursing clients. This refers to the broad category of the knowledge, skills, and attitudes required to practice in a responsible and accountable manner. It is subdivided into preparation in terms of self and protocols of nursing, associated disciplines, and organizational protocols. Readiness of the self, according to Christensen involves:

> The acquisition and upkeep of the persona associated with being a nurse... (as well as being) settled in their own selves, as distinct from their role as nurse. This means that nurses enter a Nursing Partnership totally ready to focus on the person/client rather than on their own personal worries and concerns, and have adequate resources to act. (1990, p. 188, 189).

A nurse's approach to the other in nursing encounters does indeed require the ability and desire to segregate personal concerns in order to assist the client, but the assuming of a "nursing *persona*" must also include acknowledgment that nursing is a multifaceted function. Thus the persona of nursing will simultaneously be required to address many needs, issues, demands, and concerns within the working environment. In other words, the nursing *persona* does not consist solely of the aspect offered to a nursing client in a particular nursing situation. The model, *Dance in Caring*, shows how the various aspects of the *persona* of nurse may be offered to clients, depending on the current abilities of the nurse's personal *persona*, as well as his/her perception of the client's needs. A nurse whose resources are limited may choose to interact only on a service-instrumental task level. Thus the *Dance in Caring* expands Christensen's (1990) model to incorporate and express how the myriad of *selves* (depending on one's internal and external context and resources) can be used or avoided in nursing interactions.

From this basis, how the work of the nurse, particularly the negotiating work in nursing partnerships, is chosen and offered to the client, is more understandable. The negotiating work includes attending, enabling, interpreting, responding, and anticipating. How these expressions of caring are settled within nursing encounters remain poorly understood. However, as Bottorff (1992) muses, nursing studies that do not use the communication frameworks traditionally accepted in nursing, have a better ability to capture the unique styles of caring that are characteristic of nursing practice. Such research has identified previously unrecognized expressions of caring. The politeness framework is one

such communication model that may be profitably used to identify how nursing clients perceive, accept, avoid, or negotiate these expressions of caring.

The work of the client as described by Christensen (1990) is reflected in the *Dance in Caring*. The person who is *client* does indeed assume the *persona* of client, assisted by previous personal and social knowledge and experience of what it means to be nursed. Both models utilize the assumption of individuals' ability to move from one range of social role used in normal social situations (outside of the health related event experience) to another in order to access nursing assistance. This client role requires revealing normally private physical and informational aspects of the *self* to others that are familiar by function but not by person. The act of revealing also includes a corresponding act of concealing, as the client tries by managing the self, to maintain a sense of equanimity, yet still fulfill expectations of others (Christensen 1990). The findings of this study are instrumental in describing to a greater extent how this occurs in specific communication acts. Although Christensen (1990) observed that clients learn strategies for interacting with health personnel, which allowed them to cooperate and fit in while still retaining some measure of autonomy, she does not describe how this is done. This gap is understandable when the goals of the research are identified as describing the overall process and pattern of the experience of nursing. However, the gap is a major stumbling block when the goal becomes describing how the concepts evident in this process are related and interdependent. It is proposed in this model that nursing clients fit into the health care process, endure hardship, maintain equanimity, and acquiesce to expertise but still remain autonomous, though the communicative strategies of politeness.

Christensen (1990) does note that the quality of nursing is often dependent on the vigilant presence of the nurse, the vigilance needed to select the knowledge and skills according to the client's immediate situation. However, her description of nurse activities such as coaching, ministering, giving encouragement, or even presence seems to be dependent on the nurse and clients mutual perception of the need and the situation. The moment by moment process through which mutuality and thus the response is achieved, is almost entirely ignored in the *Nursing Partnership*. This mutuality and cooperation seems to be assumed by Christensen without due consideration to efforts on the part of the client to avoid active participation, or any attitude on the part of the nurse that nursing responses or activities require specific agreement by the client. In other words, Christensen's model assumes near total cooperation between a person who has put the private persona aside in order to present a fully attending nurse persona, and a client who restricts private feeling in order to cooperate fully with the nursing goals.

Although Christensen (1990) is careful to point out that the mutual focus of client and nurse is the client's immediate and potential situation, the work that the nurse and client do is largely parallel rather than interdependent. For example, nursing actions and judgments may remain peripheral to the client's experience, as a service-task gnostic event unless the client decides to interact on a different level. The core act of *listening* as part of the nurse's continuous presence is useless unless the client chooses to communicate. Indeed, Christensen noted that evidence of listening was identifiable by its omission in nursing interaction. Christensen concluded that nurses may have to work very hard to convince some clients that s/he is ready and able to listen. If the core act of listening is resisted by the client, then one of the conclusions that could be drawn is that the client does not wish to actively participate by revealing or sharing *self* in a nursing encounter. Christensen, for some reason, fails to connect resistance to the receiving offering of nursing skills with the work of the client; to endure and to retain an appearance of public competence despite personal status. Yet, the overall relationship is described as mutually determined and client centered. The inability to comfort and care for a client without that client's consent was expressed in another section in one nurse's comments;

> I found it quite a challenge because he won't *let* you be the nurse. He likes to set the level of the relationship and lets you know when you are intruding. (Christensen, 1990, p.125) (original emphasis)

These types of areas in Christensen's work - how nurses increased and decreased the level of involvement, assistance, presence or attention - were described vaguely as individual nurses' range of interpersonal and instrumental skills, as well as nursing knowledge. However, as a model through which to interpret and understand the experience of offering and receiving nursing care it is limited, as the vital connection of how transaction is negotiated remains unclear. To use other related examples; how does encouragement, which by definition implies helping another extend their known strengths to compensate for deficits or weaknesses, occur in a way that is perceived by the client as helpful, supportive and positive, rather than negatively oriented. How can a nurse identify and communicate to a client the problems that must be overcome in order for the client to make progress, without offending, insulting, or hurting the client? The concept which Christensen uses to explain this - *interpreting* - describes nursing activities on a macro level as problem identification, selecting the appropriate nursing response, extending the clients activity level, and so on. These observations are useful on a broad level. However, there is a need to start investigating the micro communication strategies that comprise many of the larger communication constructs. Concepts such as courtesy and tact, which are

politeness strategies, are examples of the communication skills that nurses use constantly in interaction with clients. The *Dance in Caring* enhances the *Nursing Partnership* by explicating how politeness is used as a communication strategy in nursing encounters.

Anonymous intimacy, as defined by Christensen (1990), refers to one type of nursing encounter, *sanctioned privacy*, as defined in this study. This type of nursing interaction appeared to be the most predominant interaction observed by Christensen in her study. However, Christensen attributes its occurrence to the ever changing groups of nurses and clients, and thus a tendency for clients to identify with nursing rather than individual nurses. In this study it is proposed that actual numbers of nurses to whom clients are exposed is irrelevant, compared to the decisions that clients make about protecting privacy through role guided patterns of communication. *Sanctioned privacy* is thus an outcome, a descriptor of the type of interaction that occurs in routine everyday interactions.

The other possibilities, the gnostic service-task type interaction may be common in situations that are mutually perceived as superficial or otherwise not particularly important to the *self*. These are less common and are dependent on mutual agreement to conduct this type of interaction. Failure to coorient would result in an uncaring encounter, and thus fall outside the scope of this model. The greatest degree of involvement, *privileged intimacy*, the connecting between one *self* and another, without any reliance on role guidance is rare and special. In Bottorff's (1992) study, for example, this type of interaction, largely defined through touch was postulated, rather than observed in clinical nursing. The *Dance in Caring* reflects how nursing care can be offered to a specific client in a manner that is particular, intentional, and personal for the client. This offering of care can in fact be something that is a daily occurrence for the nurse. It may be a routine experience for the nurse but it may still be sincerely appreciated and meaningful to the client. It is a model about both the actuality of reality and the possibilities that nursing may contain if the nurse is willing to be open to the potential of connecting with another person using the *self* as the instrument of care.

The notion of routine particularistic nursing care

This study has contributed to the development of nursing knowledge in caring. Much of what has been proposed here is evident in the literature on caring. The most important contribution is that this study examines the ways nurses can and do care, without exhausting themselves, in an increasingly demanding environment. Way (1991) asserts that the health care system has become depersonalized and disease-cure-oriented due to the advances in medical science and technology during the last two decades. This sentiment is common in the nursing literature although its credibility must be questioned. There is no

dispute that medical science and technology profoundly influence health care, but whether they automatically result in depersonalized or disease-cure oriented (implied nursing) care is questionable.

If one listens to or reads the anecdotal recollections of nurses who have nursed through the evolving health care system this century nurses have always been challenged to preserve nursing contact in some way. The constant fact is that no matter how the responsibilities of nurses change (either assumed or imposed), nurses are able to care. The time that a nurse in the 1930's may have been able to spend with a patient may not be that different to that of a nurse today, though the reason for initiating the interaction may be different, for example administering therapeutic drugs rather than a bed bath.

In other words, the external conditions - the state of technology, or design of hierarchy - is an external influence rather than a determining factor in how nurses are able to caringly interact with their clients, no matter how short the contact or technical nature of the activity. The *Dance in Caring* model suggests one way that nurses balance these competing demands - of the external forces on caring and their own resources and abilities - in the caring they offer to clients.

Different perceptions of caring

The ideal of caring, which is implied by Way (1991) to be slipping further away as technology becomes a competing concern to the pathic needs of clients, is often regarded as being truly present with another, something that is beyond listening and being physically present. It involves knowing the *self* and other, an intentional activity motivated by a moral commitment to human dignity, connectedness as human beings, and authenticity (Watson 1985). Caring can be expressed in behavior or what the nurse does, and what nurses say (Way 1991). Burnout for nurses is often the result of being unable to give care in the fullest possible way desired (Kurtz & Wang, 1991).

It is particularly interesting to note in the theoretical discussion and research on caring, that there are differences in how nurses and patients perceive caring. Patients regard comforting approaches such as relating, being involved, sense of safety, and reassurance as important, while what is important to nurses are the affective approaches, such as empathy (Way 1991). The commonalty is the centrality of the client in terms of focus in the interaction.

Way's (1991) investigation into perceptions of parents of the nurse's caring in a pediatric unit showed clearly how concern for the child or parent could be communicated either verbally, or through action. As well as the importance of touch, nurses communicated concern through the language they used. Way reported that caring could be

differentiated from non caring by the verbal transaction. She used an example of one parent recalling that some nurses were non-caring in the way they brushed off the concerns of the parents of sick children. For example, a parent concerned about her child's wound was brushed off by the nurse " 'It's just the way it's healing'" whereas a caring nurse would respond "'Oh yes. We have to make sure the doctor sees that'" (p.45).

The genuineness of a nurse's concern was perceived through the quality of touch and facial expressions. Many of the examples offered by Way (1991) were similar to the types of politeness strategies used to manipulate social distance, active participation, and control in interaction. To illustrate, the uncaring statement made above, is impolite. It is a direct indication that the mother should not interfere with the child's care. The second response, regarded as caring, in some ways avoids addressing the problem of the child's wound directly, but this is veiled through use of solidarity (*We* will do something about this), and an implied promise that the wound will be seen by the doctor. Way (1991) does not report whether this actually occurred. The way in which each nurse responded to the parent in this verbal interaction, indicates a different approach to caring, respecting the parent's right to be involved and responsible for the child, as well as acknowledging the understanding the parent might have of the child's healing. These are positive and negative face wants.

Further examples are found in Way's (1991) report that parents' perception of nurses' caring was being in tune with the parent, so that caring actions could range from suggesting a parent leaves to eat to making drinks for the parent, as well as being present, comforting, and listening. The essence is that nurses are sensitive to the parent's needs, so that the actual behavior did not have to be an out of the ordinary attitude or action. Some nurses were caring if they shared their own experiences or if they were able to cry with the parents. Other parents thought that this sharing and emotional investment was not caring, as it was overpowering or deflecting concern from the parents or child.

In Yonge's (1989) study of nurses and psychiatric patients' perceptions of constant care, patients thought that nurses communicated caring by tone of voice, attitude of acceptance, making the patient feel that he/she was the priority, willingness to help, being sensitive to the patients mood and need for superficial conversation, and withholding the negative feelings that the nurse must have felt to the patient. Nurses showed caring by using their personality, being quiet, calm, involved, agreeable, comfortable, and versatile in conversation or able to talk about any subject. Some patients preferred nurses who were willing to respect their privacy, even in the difficult situation of constant care and observation. In this type of situation, the issue of privacy, whilst still being closely observed, becomes paramount. Patients, no matter how sick they are, still have the right to

a sense of privacy which the nurse can create without leaving their side. For example, Yonge (1989) noted that nurses facilitated this through avoidance of eye contact, distracting talk or activities (such as helping pick out clothes while the patients is dressing or washing).

The central theme in the patients' perceptions of constant care in Yonge's (1989) study remains the appropriateness of the attitude or approach in terms of the needs of the patient, rather than the specific action. The central theme of the *Dance in Caring* may be the key to understanding how these needs are expressed and settled in the social communication that occurs in conjunction with nursing activities. Politeness is one way for a nursing client to express, without risking positive or negative face, a need that may not be directly related to the activity to be initiated or that is in progress. It is one way that clients may very subtly indicate that more privacy would be appreciated or that a caring action may in fact directly impose on a negative or positive face.

For example, a nurse suggesting to a parent that a break away from a sick child would be a good idea is unlikely to occur unless the nurse perceives that the parent needs the break to regain composure or control over his or her feelings. The suggestion would have to be very sensitively offered if the parent appears unable emotionally to be separated from the child, or appears to resent any suggestion that the level of coping is slipping. The results of successful expression and recognition of caring are the characteristics and examples described by Way (1991) and Yonge (1989). The manner in which these may be settled may include politeness.

The special nature of nurses

Way (1991) reported that parents believed nurses had to be very special people to care, to deal with the pain they see everyday. Some nurses were seen to have a generally caring nature, others seemed cold, distant, and unaffected. In Yonge's (1989) study, the ability for a nurse to have some way to have time for *self* even though the patient was accompanied at all times, was essential to coping with the strain of constant care. Nurses used light but interesting books, knitting, or writing letters as a way to distract and recollect, yet still remain alert and able to reorient to the patient quickly.

Understanding how nurses maintain a caring attitude in nursing encounters when faced with constant suffering is one of the most important contributions of the *Dance in Caring*. How nurses offer sincere care and conserve personal energy is one of the central themes of the *Dance in Caring*. Nurses communicate in many ways, politeness is only one verbal manner of being able to simultaneously protect self without appearing to intentionally avoid the other. This is illustrated by the following discussion the researcher had with a clinical

nurse. This discussion demonstrated how important the ability to maintain personal distance from the patient without being perceived as uncaring is to nurses' coping. This nurse recently left an inpatient unit to work in home care. The nurse said:

> The difference in homecare is that you can go in ready to be attentive and concerned. Then, you can leave and change tracks for a while, talk about something else, until the next visit. In inpatient care, you cannot do this. You are at the beck and call of all the patients the whole time. You must be able to put a barrier around yourself, or you just become burned out. It doesn't mean that you don't care, it just means that you're not continually putting out your personal energy. In community care, you have time to regroup your energy between contacts. You don't get that in inpatient care.

In sum, caring is a complex area of human interaction. Leninger (1988) believes that holistic caring is difficult to study in a way that does not mechanically reduce it to parts. This study has not specifically addressed caring; rather it has addressed how nurse and client interaction influences a particular perception of type of caring. However, it has contributed to the understanding of how caring may be negotiated in nursing interactions. This model *is* somewhat mechanical. It describes four stereotypical types of nursing interactions, and thus does not reflect the myriad of nursing interactions that lie within and between each interaction quadrant. This is an unfortunate aspect of a study that was intended to try to understand how nursing care can be offered and perceived by people who are mostly strangers to each other. Further development of *Dance in Caring* needs to focus on integrating the model into the larger context of caring.

Mediators in nursing interactions

One of the greatest limitations of this model is the sole concentration on verbal forms of politeness as a mediator in nurse-client interactions. Politeness can only be considered as one of the mediating factors. Future research needs to include other factors, most notably touch. Bottorff (1992) has described how the different ways a nurse chooses to touch are an indicator of the type of relationship or contact existing between the nurse and client. A focus on task, when that was critical or demanded all of the nurses attention, resulted in less sensitivity to the patient's concerns of distress. What is significant, although mostly ignored, in the examples she presents, is the verbal forms of politeness that the nurse uses in these instances. She described five types of touch (comforting, connecting, working, orienting and social touch) which could not be divorced from the verbal communication accompanying or preceding it. In other words, Touch was embedded in the context of the interaction, which included verbal communication and instrumental concerns. Bottorff`s (1992) interest was in the nature of the touch, but verbal communication was noted as intrinsic to the way nurses initiate and maintain interactions with clients. It is very

interesting that in this study, verbal communications were perceived to have little relationship to the nature of the touch. The data analysis coding guides used gross measures to analyze the nurse-patient dialogue. This type of coding is unlikely to identify instances of attempts to move the level of interaction, through avoidance, distraction or ambiguous forms of politeness. Bottorff concluded that *how* nurses and patients negotiate different levels of involvement , need and response, is still unclear.

Bottorff (1992) also notes a major assumption underlying the concept of the nurse attending to a client is that single behaviors do not define a type of attending; it is a particular combination of behaviors that occur across a wide range of activities engaged in by nurse and client. It is these activities that should be recognized as attending irrespective of the individual characteristics of the nurse, the client, or the situation. She concluded that individual nurses are capable of using a range of attending styles, and often use several during any interaction. She also postulates that the amount time spent with a patient is not one of the determining factors that influenced the type of attending. She further notes that types of attending do not contain implications importance or effectiveness if used appropriately. In other words, if the nursing client appears to want distance and privacy, then the nature of the nurse's attending should reflect this. The equivalent in *Dance in Caring* would be offering gnostic contact.

Bottorff asks the question of what other factors influence attending styles. She suggests that the clues provided by the patient's obvious active participation and differing types of participation in the interaction implies that it is an interactional process, rather than a nurse driven one. Patients, she observed, were able to initiate a change from one type of attending to another through verbal maneuvers. Nurses and clients had choice in how to respond to attempts to change the type of interaction. The type of attending was the result of the interplay between nurse and patient. Bottorff's (1992) results support the evolving model of the *Dance in Caring*.

Bottorff also described level of involvement and commitment that are very similar to this model. In both studies, the type of relationship was determined by both patient's desires for a particular type, and the nurse's desire for a particular level of involvement. The difference between Bottorff's (1992) study and the present study is that Bottorff used individual interactions to create models of types of relationships, whereas in this study, the nature of the contact is indicative only of specific nursing encounters rather than whole relationships. The relationships are similar to the *Dance in Caring* interactions of *gnostic* interaction, *sanctioned privacy*, and *privileged intimacy*. She described the relationships as follows; "clinical" relationships were characterized by little emotional investment, and were

courteous although interactions were played out in a rote or perfunctory fashion; "therapeutic" relationships were based on individuals assuming roles of patient and nurse, but with limited recognition of the person behind the role; "connected" relationships were intimate and close contact was based primarily as persons with a secondary focus on roles of patient and nurse. The fourth type of relationship "over-involved" occurs when the two were committed to and interact on a person-to person basis with no influence from respective roles. This last type of relationship was not observed in Bottorff's study. The similarity between Bottorff's "over-involved" relationship and this study's *sanctioned privacy* and *privileged intimacy* is not clear. There are characteristics of the "over-involved" relationship in both types of interactions. This indicates that the nature of interaction in the *Dance in Caring"* requires further development and refinement. It is postulated that further refinement will result in many more levels of interactions being described.

Future Directions for Research

Although there are aspects and co-existing factors that have not been addressed in this study, the model is at a sufficient level of development to warrant validation in clinical practice. The first stage in clinical research would be investigation into the use of politeness in nursing interactions. Most of the recent research on politeness in naturally occurring conversations have involved audio taping, and (rarely) videotaping interactions for analysis, either descriptively or in an attempt to build taxonomies. Video taping is often cited as a useful addition to understanding verbal exchanges, but its use has been limited by the nature of the interaction. In very private interactions, videotaping is regarded as unethical or overly intrusive, resulting in inhibited interaction. It is proposed that audio taping of nurse-client interactions should occur in a variety of nursing settings, and be combined with observations by the researcher, and interviews with the research participants, to gain perceptions of the nurse and client in terms of what they perceived and felt in the encounter. Analysis would be at the descriptive level, and focus on identifying the types of politeness strategies, and associated verbal strategies (such as verbal play) that are used to achieve gnostic and pathic goals.

Limitations of the study

It is acknowledged that individuals selectively remember what they have perceived through their own perceptual set (Salisberry, 1989). This study is limited by the abilities and the perceptions of the researcher. As a theoretical model, it will remain the idea of one particular person until further research validates and modifies it through investigations in clinical practice. This model has been developed through a helix-like process of idea

generation, critique, and redevelopment. It was impossible for the researcher to totally bracket held assumptions and beliefs insofar as these may not have been present in conscious thought. The resources of the researcher also means that some factors known to be part of the way in which nurses and clients communicate, notably touch, have not been addressed. This study has been focused on the verbal strategies of politeness in social interaction. Further development of the model should recognize how non-verbal communication also contributes to nurse-client interactions. As the researcher's experience and understanding grows, so will this model develop.

Despite these limitations, this model provides an unique insight into a different way of interpreting how nurses and clients negotiated an interaction that is sufficiently meaningful to meet the client's gnostic and pathic needs. This model may be useful in nursing education as a complementary way of introducing nursing students to communication skills and interpretation of nurse-client interaction. The model may help sensitize nursing students to the ways in which clients indicate their needs and the type of nursing response necessary to meet those needs. This model also presents a challenge to nursing curricula in that the manner in which nurses use communication framework to interpret caring must become more varied than they are at present. The politeness framework and the model of the *Dance in Caring* raise questions for consideration, the main one being: What effects do different conceptual frameworks of caring and communication have on a nursing students' ability to be caring and to communicate that caring?

Summary and Conclusions

The purpose of this study was to develop the concept of *anonymous intimacy* through a theoretical analysis of the literature. It is anticipated that the result, the theoretical model of the *Dance in Caring* may assist nurses to understand how caring interactions are initiated, maintained, and negotiated to meet the needs of the nursing client, and simultaneously provide a sense of privacy and safety of the private self through use of role guided communication. The central theme of politeness as a communication strategy to control the level of interaction, social distance, formality or informality, and intimacy or privacy has largely been ignored in the nursing literature. This study is a contribution to the literature on nurse-client caring interactions.

The theoretical analysis of the literature involved a critical review of the research, theoretical and expert opinion literature directly relating to the concept of *anonymous intimacy*. Concepts, and categories were drawn from the nursing, psychological, sociological, anthropological, and communication literature, and synthesized to form a model of the ways nurses and clients interact in nursing encounters. The study was initially an attempt at concept synthesis. However, the researcher concluded that the concept of *anonymous intimacy* was not a singular concept but a descriptor of a particular type of nursing interaction. Following this discovery, data from the literature were synthesized into a multidimensional model of nurse-client interaction. The central theme of this model was the concept of politeness, or the social efforts to maintain one's positive (want to be seen desirable and competent, one's self esteem) and negative (want to be autonomous and have freedom of though and actions) faces. The politeness model was drawn from the Brown and Levenson (1987) theory of politeness.

It was found that one of the fundamental features of social life is the ability to assume role characteristics in social interaction as a way of interacting with a stranger. Assumption of roles also serves to protect the individual's private *persona* from public view. In nursing interactions, both nurse and client use the strategies of politeness to mutually determine the focus of the interaction, the client's gnostic or pathic needs, and to negotiate how the interaction will proceed. A gnostic type relationship indicates that the client concern is addressed on a cognitive level: that is, a level in which the concern is objectified and removed from the rest of the client's being. This allows the nurse and client to interact on a level that is guided by assumed role behaviors. The concern does not require anymore than a service-task relationship. The second level of interaction, *Sanctioned privacy*, occurs when the client indicates that there are pathic, or subjective concerns to be addressed. The nurse chooses to attend to these needs, by making an aspect of her personal *self* available.

The nurse and client coorient to the concern, and in the process create the conditions in which the client feels adequately secure to express pathic concerns. The nurse, although responding sincerely and caringly to the client, uses resources gained from nursing to respond. The nurse is able to maintain distance, thus conserving and protecting the private *self* and persona. Politeness is used to ensure that the client is aware of the nurse's concern, empathy, and willingness to help. The third level of interaction, *Privileged intimacy* is a rare and special type of nursing encounter. It is characterized by true genuiness and presencing, a connectedness between the *self* of the nurse and the *self* of the client. Role boundaries are not predominant in this type of interaction. The last type of interaction, *Forced gnostic* characterizes those situations where the nurse and client have a previous relationship that is not congruent with the requirement of the present situation. In these instances, nurse and client will rely on role guided patterns of behavior, and politeness to increase the social distance and formality as a means of dealing with any embarrassment or sense of threat to the friendship based relationship.

This theoretical model is limited by the knowledge and experience of the researcher. It is anticipated that the model will evolve further through continued critical reflection and validation in clinical practice. The next stage in research is to investigate the use of politeness in clinical situations. In spite of the limitations of this model, it is important in that politeness has been an ignored aspect of nurse-client interactions in nursing research. The findings have relevance to nursing practice, in that they suggest a way in which nurses can sincerely offer appropriate nursing care to clients, while still preserving their inner resources; to nursing education, as one of the communication strategies nurses use to create and sustain nursing relationships within each nursing encounter; and nursing research. While the answers to the questions posed at the commencement of the research project have been answered, more questions have arisen which merit exploration.

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Appendix A

STUDY PURPOSE AND RESEARCH METHOD

The question of "what is *anonymous intimacy*?" was not primarily a factual question. The question was conceptual in nature, which involved questions about actual and possible meanings. Defining this concept required that not only actual meanings be considered for relevance, but that new meanings that could serve a particular purpose be proposed for those areas in which meaning is absent or insufficient. The synthesis of new meanings was a qualitative, creative process equally dependent on and limited by, the abilities of the researcher. The creation of new meaning has dangers in that unsubstantiated ideas are useless as a contribution to nursing knowledge, although exclusive reliance on existing knowledge also has the same effect on advancing nursing knowledge. To address the question of "what is *anonymous intimacy*", a balance was required; the flexibility to create and synthesize, and the rigor and trail of validity and reliability of nursing research.

A theoretical analysis of the nursing and related literature was viewed as the most effective manner of achieving these goals and standards. A theoretical model of the attributes, characteristics and boundaries of *anonymous intimacy* was identified as the second step of concept analysis. Following this, though not a part of this project, would be clinical research to validate or modify the theoretical model. Thus, the purpose of this study was a theoretical analysis of the nursing and related literature; to search, analyze, and re conceptualize the existing literature directly and indirectly related to the topic, in order to develop a beginning model and propositional statements about the nature of the concept of *anonymous intimacy*.

Method

As this study evolved, it became obvious that there was a need for flexibility to consider the range and contributions of both actual and potential meaning of terms. As Wilson (1969) points out, it is essential to avoid regarding abstract objects, such as the words "intimacy" and "anonymity" as things (which will then have a "right" answer), rather than simply as conventional signs or symbols which evolve according to the practical ends of the user. As the study progressed and the researcher determined that the answer to the research questions was not bound by the definition of intimacy and anonymity, it was deemed necessary to take concepts and manipulate the meanings to see how, or if they would be congruent within the concept. The data gained from the literature acted as keys and foundations for the researcher's creative ability.

Sample

The descriptive, research, theoretical, and expert opinion literature from the disciplines of Nursing, Sociology, Medical Sociology, Social and Individual Psychology, and Philosophy were the main sources of data. The literature was used to provide data that substantiated a particular claim, or as a point from which the researcher started to speculate and manipulate meanings and application of meaning.

The admission criteria for admissible literature was defined initially by the substantive characteristics, or keywords that were already known to be applicable to the research topic (Curlette & Cannella, 1985), or that evolved during data analysis. The process of analyzing and re conceptualizing the literature modified those keywords, and indicated further sections of literature should be addressed, or that were noted to have possible applicability, but which must be laid aside.

The inclusion criteria for admissible literature included all types of literature. The exclusion of certain sections of literature due to methodological problems, excessive diversity, or length of time since publication, was undesirable as it is the diversity of uses of meanings rather than the quantification of studies that contributed to the evolving model. Year limitations of publication was not necessary, as suggested by Broome (1993) because the focus was not on the evaluation of the current state of knowledge as defined by published research findings, but on the qualitative synthesis of data to define terms and concept characteristics. The initial keywords were as follows:

Anonymity - non-person
Comfort
Confidentiality
Depersonalization
Distancing
Empathy
Gift giving
Interpersonal relations
Intimacy
Nurse-Patient relations - quality of - nature of
Nursing theory
Objectification
Paradox
Personal boundaries
Presence
Privacy
Professional relations
Rapport
Reciprocity
Role - role theory - symbolic interaction - expectations - behavior - enactment of - professional roles
Self-disclosure
Social distance

Stranger - sociological and anonymous stranger
Therapeutic relationship
Trust

Over time, this list changed, as sampling was directed by the needs of the emerging analysis (Morse, 1989). Some of the terms were not pursued due to the researcher's limitations in time, and others were found to be of limited use in contributing to expanding or confirming understanding of the concept. The identification of the core variable - politeness - determined other relevant key terms, such as face-work, coorientation, and attending.

The search process

The documentation of the search and retrieval process in the theoretical analysis provided evidence of the reliability and validity of the decision making audit trail. Part of this consisted of determining admissible literature. Documenting the decisions regarding the search and retrieval of article/books was one way of identifying possible biases as gaps or reliance on a particular type of literature was noticed. Eventually, a decision to focus on the politeness and face-work literature was made when it became obvious that the key to *anonymous intimacy* was the mechanism of reconciling the paradox. Politeness is only one of the possible social processes that occurs in nursing interactions, but the decision to pursue this section of the literature contained the equal decision not to pursue another possible route.

The search and retrieval process was recorded in a code book. This record eventually enabled the researcher to identify the links between the apparently diverse ideas being pursued in the literature. It enabled the researcher to identify the major categories and the concepts subsumed within these categories.

Five primary methods of search and retrieval were used. These methods are described by Cooper (1982) as:

1. ***Computer Search*** of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Psyche Abstracts, MEDLINE, Sociological, Anthropological, Health Plan, and the University of Alberta Library on-line catalogue. Searches were initiated with the identified and evolving keywords.
2. ***Descendency method***: The indexes of books were perused to find papers pertinent to a topic.
3. ***Ancestry***: Citations were tracked from one study to another. This was an important method of identifying branching of ideas, and as means of discovering how concepts have been developed over time, and adapted to different contexts.
4. ***Browsing***: Literature discovered in the process of searching for other articles or found

incidentally proved to be a vital source of information. The researcher developed a systematic habit of browsing through the three most recent years of the journals immediately around the journal or volume of interest. This practice lead to the discovery of a branch of the politeness literature (concerned with naturalistic observation of politeness) not identified through computer searches, and not referred to in the politeness research based on simulated laboratory tests.

5. ***Invisible college*** (or fugitive literature, according to Curlette & Cannella, 1985)
This is the information and unpublished ideas identified through the researcher's formal and informal professional networks.

Extraction of information

The annotation of articles from the literature refers to the extraction of specific information from the article. The purpose was to summarize and document the important content in a concise and retrievable manner (Broome, 1993). As this study was a continuation of work in progress, some articles already possessed by the researcher were not fully annotated. However, the researcher did note that when an article was re-reviewed, the current review was in light of specific new perspectives. Each article was coded under the following headings:

Title:

Author:

Date:

Reference:

Classification: Research, descriptive, theoretical, expert opinion, or personal

Discipline:

Search keyword used:

Verbatim quote of relevant information:

Paraphrased description of context of information:

Theoretical Memo: Identification of the importance/implication of information. This section eventually was under utilized as the need to connect ideas went beyond specific articles. Much of the theoretical memoing was in the researcher's code book/ diary or on separate pages of computer files.

Data analysis

Coding, analysis, interpretation, and re conceptualization of the data occurred concurrently with literature search and retrieval. Data analysis and data retrieval were a cyclical process of coding and classifying data into main key terms or codes, continually critically analyzing data and codes for clusters of meanings that seemed to be related; and

looking for hierarchical structures to determine existence of dimensions of concepts and relationships between concepts (Walker & Avant, 1983). Data analysis determined the direction of future data collection as gaps or themes were identified in the emerging model. The techniques of enhancing theoretical sensitivity, such as imagining the opposite of what was indicated, critical analysis of single words or phrases, comparing the very similar and very dissimilar, but most of all critically looking at what was assumed, enabled the researcher to analyze and re conceptualize the data using experience and knowledge with creative skepticism (Strauss & Corbin, 1990). Analysis of the literature was accompanied by theoretical, methodological, contextual and analytical documentation or memoing (Rodgers & Cowles, 1993) to record the audit trail of decision making in sampling, data analysis, and personal insights about the emerging model.

The main procedures for data analysis was reflecting on and questioning the data. At times, this seemed to take on the appearance of conversing with the data. This running conversation was useful in examining the contributions, conflicts, discrepancies and ambiguities in the data with the emerging categories and codes (Manchester, 1986). Eventually, realization of the irreducible variation in the possible dimensions of the concepts of intimacy and anonymity indicated the pivotal function of politeness as the key to relationships between categories or meanings (Strauss & Corbin, 1990).

Reliability and validity

The researcher was the main instrument in this study. The quality and depth of data analysis was dependent on the ability of the researcher (Field & Morse, 1985). As a novice researcher, this study is limited by the researcher's abilities in theoretical thinking, and by her limited resources in time to pursue data and resources to retrieve it. Although the library staff at the University of Alberta's libraries were very helpful in tracking material, some important documents were unable to be obtained in sufficient time through the interloan service. Communication with the researcher's colleagues and research supervisor was used to evaluate the credibility of the findings as alternative interpretations were identified and considered.

The research process was influenced by the researcher's personal conceptualization set, background and knowledge relative to the study area. Personal biases are evident in the selection of particular approaches to concepts, as well as the decision to focus on one particular aspect of the integrating mechanism of the model. This is not necessarily a negative feature as long as the limitations affecting the credibility of the findings are acknowledged (Rodgers & Cowles, 1993). The researcher's primary bias at the beginning of the study was the belief that the concept of *anonymous intimacy* does exist, can be

identified through existing literature, and is a commonly experienced aspect of the nursing relationship not consciously recognized by nurses or their clients. As the conceptualization of the model progressed, the most predominant bias was that politeness was the communication strategy that was fundamental to how nursing interactions are initiated and negotiated. The researcher acknowledges, however, that as this research process has produced a perception of *anonymous intimacy* previously unimagined that future evolution may also change it beyond current recognition.

The primary means of ensuring reliability and validity was through explicit description of the data. The trustworthiness of this study refers to whether the research answers represent reality and are not distorted by internal procedures of analysis (Field & Morse, 1985). This is a difficult aspect of this study in that at times, there were deliberate attempts to synthesize or create a new meaning beyond what was established by the original author. Instances of this were identified by the researcher as using a particular concept or approach, but speculating or proposing meanings beyond this. Thus, what is known, and what is proposed is clearly identified throughout the work.

Memoing was a crucial process for several reasons. It provided an ongoing record of theory development; the contextual background of data, the evolution of the findings, and the researchers ongoing reaction and orientation to the data. It was important to maintain accurate and comprehensive notes or memos related to the impetus and rationale for all methodological decisions; to record important decisions about the selective theoretical sampling, shifts in the focus of research questions and the emerging model, and also to record lines of analysis that are not pursued (Rodgers & Cowles, 1993). The audit trail system of documentation to be used in this study consisted of:

1) ***Contextual Documentation*****:** Descriptive accounts of the context of extracted information were maintained as part of the annotation of each article/book. This documentation recorded the researcher's insights and changing perspectives of the data. Part of the contextual documentation will include the evolving diagrams of the shape of *anonymous intimacy*.

2) ***Methodological and Analytical Documentation*****:** A record of the codes used to guide data collection was maintained to identify the rationale of all methodological decisions. This included keywords, and decisions regarding strategies for conducting the study as the model emerged. Insights and thought processes about the model were also noted so as a record of changing perspectives and emerging ideas.

Ethical considerations

There were no ethical considerations as the data were extracted from published sources. Academic honesty and standards in regard to the acknowledgment of sources of ideas from published and unpublished sources were maintained according to the University of Alberta Academic Regulations. Data outlining the audit trail will be kept for at least seven years after the completion of the study.

Appendix B

POLITENESS STRATEGIES

(Adapted and condensed, with permission of Sage Publications, Inc., from the work of Lim, T., & Bowers, J.W. (1991). Facework: Solidarity, approbation, and tact, *Human Communication Research, 17*, 415 - 450, © 1991 International Communication Association).

Type of face: Fellowship want.

Fellowship refers to acceptance of another as a member of the group. It is addressed by solidarity, positive politeness, and agreement or sympathy; through use of in-group identity markers, expression of empathetic understanding, demonstrations of personal knowledge, and cooperation.

1. Solidarity strategies: There are two criteria for identifying these strategies: the degree of interpersonalness / in-groupness, and how directly this is expressed.

High solidarity:

- ❑ *Friendship reaffirmation* of intimate emotions: "you are a good friend", "I like you".
- ❑ *Cooperation* : emphasize need for helping each other.
- ❑ *Empathy:* show understanding of other's emotional state; "I appreciate what you did for me", "you look sad", "I understand what you are trying to say".
- ❑ *Character appreciation of the general personality of other:* "that is very kind", "you are very nice".
- ❑ *Social acknowledgment:* appreciating the work-related aspects of other; "I know you are busy", "you really are enthusiastic".
- ❑ *Agreement; to agree or to seek agreement:* "I think so too, do you agree?", "You are right"
- ❑ *Informal address:* "hi pal", "buddy", "Jimmy".
- ❑ *Attitude similarity* in wants, hobbies, attitudes: "I like your...", "Do you like...", "it is my favorite...".
- ❑ *Impersonal similarity or generalized similarity:* "Wow, isn't that nice?", "We are both ..., aren't we?".
- ❑ *Small talk:* talk about something that has no implications for the relationship; the weather, news, and other public topics..

Low solidarity:

- ❑ *Exclusion* : "it is none of your business".

Competence face want

This refers to approach based politeness strategies that show appreciation of other's competence or general abilities, and particular possessions or performances as the reflections of those abilities. It is addressed by approbation which is characterized by the effort to minimize blame and maximize praise of the other by voicing compliments on

abilities, and understatements of inability's or unsuccessful performance. The important principle in identifying or measuring approbation is to approve of the other if at all possible, and if not, to minimize both the quantity and quality of the problem.

High approbation:

- *Admiration:* most face saving; approval without reservation.
- *Support:* approve some aspects with minimization of problem.
- *Contradiction*: approve some other aspect without understating problem.
- *Suggestion*: suggest ways to make performance even better.
- *Diminutive:* trivialize problematic area.
- *Aspiration:* to aspire to a better performance; "I think it can be improved".
- *Resentment:* of other's lack of effort.
- *Moderation:* compare the major part with the certain desired state.
- *Comparative disapproval :* compare whole performance with certain desired parts.
- *Focused disapproval:* shift focus of disapproval from the whole to the major part.
- *Blunt disapproval:* disapprove without understating the problem.

Low approbation

- *Ridicule*: belittle the other by exaggerating the problem. This is the least face saving strategy.

Autonomy face want

This refers to avoidance based politeness strategies that express that the speaker respects the other's freedom of action and autonomy. It is addressed through tact. Tact is characterized by an effort to minimize loss and maximize gain of freedom of action by giving options, or being indirect and tentative. There are two important principles in identifying and measuring tact; the actual amount of imposition and the directness in expressing the selected amount of imposition, and intention to give options.

High tact::

- *Imposition sharing:* sharing the responsibility.
- *Experimenting*: explore the possibility for the other to volunteer.
- *Unconventional in directness:* not to state the imposition explicitly.
- *Debt incurrance:* to imply that the other will do one a favor by accepting the request.
- *Subjunctive mood possibility inquiry:* to ask possibilities using subjunctive mood

- ❑ *Conventional in directness;* "I was wondering if...." "is there any way you could...", "I would like to ask you what you think about....".
- ❑ *Indicative mood possibility inquiry:* "What do you think about.....?"
- ❑ *Indicative mood conventional in directness*: to use a conventional form of indicative-mood indirect request; "Can you .... ", "Will you....".
- ❑ *To advise*: to advise the other what to do.
- ❑ *Please*: to use a conventional politeness marker "please".
- ❑ *Need*: to state one's desire; "I want you to..."
- ❑ *Obligation:* to invoke the other's obligation; "you have to...".

Low tact;

- ❑ *Order:* to demand forcefully

These are least face saving as they make little effort to minimize the imposition or to be indirect.